Media

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Foster Care Medicaid Basics

- Each foster child has a separate Medicaid case. The foster child is listed as "PI" on this case.
- Medicaid eligibility is determined for an entire month.
- A foster child must be a U.S citizen or qualified alien.
  - Birth, citizenship and identity verification are required.
- A foster child must be a resident of Utah.
  - A foster child receiving Title IV-E assistance from any State is eligible for Medicaid in the state in which the child is residing.
  - A foster child from another State, who does not qualify for the Title IV-E assistance is considered a resident of the State that has custody and is making the placement. These foster children are not eligible for Utah Foster Care Medicaid.
  - A Utah foster child who is not IV-E Eligible and is placed out of state, may remain open for Utah Foster Care Medicaid if they meet all the requirements.
- A Social Security Number is required for Medicaid eligibility.
- Duty of Support must be completed by the agency that has custody of the child and forwarded to ORS.
- Third Party Liability (TPL) must be completed for each foster child, and submitted to ORS.
  - Do not deny Medicaid assistance while waiting for TPL information.
- A foster child must meet the age requirements for the specific Medicaid Program used to determine eligibility.
  - Age requirements vary for each Medicaid Program.
- Medicaid Eligibility of the foster child is determined on the income and assets of the child only, **unless the child is in custody through a voluntary placement agreement.**
  - When a foster child is placed in State Custody through a voluntary agreement, the FC Medicaid eligibility must be determined using the parent's income and assets (if applicable), unless that child is IV-E Eligible and IV-E Reimbursable.
- A Foster Care Maintenance Payment must be made on behalf of the child in order for the child to be Foster Care Medicaid eligible.
  - A child placed in the home of their parent is not eligible for Foster Care Medicaid.
  - A runaway child is not eligible for Foster Care Medicaid.
- A foster child may be determined eligible for Medicaid using any one of several different Medicaid Programs.
- Medicaid Policy Manuals are available on the Internet at:

http://utahcares.utah.gov/infosourcemedicaid/

Medicaid Programs of Choice

Foster Care

- DD/MR Waiver
- Nursing Home (State Hospital placement)
- Foster Care Medicaid
  - ✓ IV-E
  - ✓ Blind/Disabled
  - ✓ Children's
  - ✓ Prenatal
  - ✓ NB/NB+
  - ✓ Pregnant
  - ✓ Emergency

Foster Children who are not eligible for Foster Care Medicaid can be eligible for Medicaid programs through BES or DWS.

- Disabled Medicaid
- Family Medicaid Programs
- CHIP
- PCN

Adoption

- DD/MR Waiver
- Nursing Home (State Hospital)
- Subsidized Adoption

SA Medicaid is the program of choice over the Medicaid programs listed below. If a child that is eligible for SA Medicaid is open for one of these programs, notify the worker to close that Medicaid program and open the SA Medicaid.

- Disabled Medicaid
- Family Medicaid Programs

Subsidized Adoption

A subsidized adoption refers to the adoption of a child with special needs where an adoption assistance agreement is established between the adoptive parents and a state or local government agency. The adopted child may qualify for either Title IV-E or State adoption assistance.

A child who has an adoption assistance agreement in effect with a state or local government agency is eligible to receive Medicaid. It does not matter if the child is receiving a monthly cash subsidy. **There is no income or asset test for this type of Medicaid.**

DD/MR Waiver

Clients who are eligible for the DD/MR Waiver would be medically appropriate for institutional care. This waiver offers incentives for the client to remain at home or to live in a community setting like a group home. These clients are eligible for medical services that are not generally available to Medicaid recipients, such as day treatment programs, supported work, respite care, and group home placement.

The DD/MR worker will maintain information on clients who have been approved for the Waiver.

Nursing Home (State Hospital)

To qualify for Institutional or HCB Medicaid, a foster child must fit into one of the categories of coverage. AB&D Medicaid Section covers the categories for people who are Aged, Blind or Disabled. Family Medicaid Section covers the categories for children and for adults who have a dependent child in their home.

A person residing in a medical institution or who wants coverage under an HCB waiver program must meet the non-financial criteria for one of the Medicaid categories of coverage. Unless otherwise specified, the person can meet any one of the categories of coverage including Aged, Blind, Child, Disabled, Family or Prenatal coverage groups.

Disabled/Blind

A foster child receiving Supplemental Security Income (SSI) may be eligible for Medicaid. For a person under age 65, receipt of SSI means the person meets the disability or blindness criteria and the Citizenship/Qualified Alien Status requirements for Medicaid.

An individual must meet Social Security's definition of statutory blindness or the criteria for having a disabling condition to qualify for Blind or Disabled Medicaid.

- **Income - 100% of Poverty Level** *(Income of an SSI recipient is not countable)*
- **Assets- HH 1 $2,000**

Income spend down is allowed.

IV-E

The First type of assistance provided to children in the custody of the state is referred to as Title IV-E assistance. Title IV-E eligibility is based on AFDC eligibility criteria in place in July 1996. Children receiving Title IV-E assistance are eligible for Medicaid under the FC/F program type.

- ✓ **See Title IV-E Foster Care Manual for income and asset information for initial and ongoing eligibility.**

Children

The second type of assistance provided to children in the custody of the state is referred to as Title XIX (Medicaid) assistance; Title XIX means Medicaid. Children receiving Title XIX (Medicaid) assistance may qualify for Medicaid under the FC/C program.

- **Income - BMS level**

  HH 1-$382

- **Assets - HH 1 $2,000**

Income spend down is allowed.

Newborn/Newborn +

The Newborn Medicaid program covers foster children under age 19 who do not qualify for coverage under Children's and whose income does not exceed the income limit for their age group. This program covers children in two age groups. There are different income and asset rules for each group. The first group, Newborn (NB), covers children age 0 through the month in which they turn age 6. The second group, Newborn Plus (NB+), covers children age 6 through the month in which they turn 19.

NB(under age 6)

Income - 133% of Poverty level

Assets - no assets test

NB+ (age 6-19)

Income - 100% of Poverty Level

Assets - $2,000 HH 1

Cases will be open FC/C in PACMIS.

No spend down allowed.

Prenatal

The Prenatal Program (PN) covers pregnant foster children that do not qualify for coverage under Children's and whose household net countable income does not exceed 133% of the federal poverty level for the household size. Once the pregnant woman is determined to be eligible for PN, she remains eligible through the end of her pregnancy and for an automatic postpartum period regardless of changes to the household's income and/or assets.

- ✓ **Income - 133% of Poverty Level**
- ✓ **Assets - $5,000 asset spend down allowed**

No income spend down allowed.

Pregnant

Consider PG Medicaid coverage for a pregnant foster child only if she does not qualify for coverage under any other Medicaid program.

- ✓ **Income - BMS Level**

  HH 1 $382

- ✓ **Assets - $2,000 HH 1**

Incomes spend down allowed.

Emergency

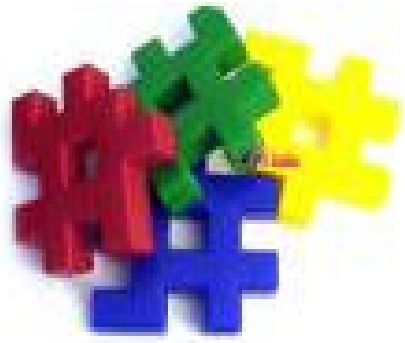
Emergency Medicaid is not a separate type of Medicaid. Emergency Medicaid provides coverage for only emergency services to individuals who meet all the requirements for a Medicaid program but are not U.S. citizens and do not meet the eligible qualified alien status requirements for full Medicaid coverage.

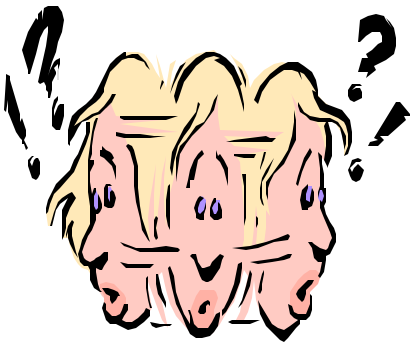
There are no special considerations for ineligible aliens for deeming income or determining household size. Follow the rules for the program type for which you are determining eligibility.

Foster Care Independent Living Program

Individuals aging out of the Foster Care System can receive Medicaid from age 18 until age 21 under this program. These youth must meet the following criteria:

- 18 years old but not 21 (eligibility runs through the month in which they turn 21)
- In Foster Care on their 18th birthday, under State custody through DCFS or DHS if the primary case manager is DCFS, or in the custody of an Indian tribe.
- Not eligible for another Medicaid program that does not require a spenddown or premium payment.
- Referred by DHS or a tribe as an individual in the Foster Care Independent Living program.
- Not in the custody of DJJS.
- No income or asset requirements.
- This program may be used for youth who remain in custody after age 18 if they don't meet the requirements for another Medicaid program.





What are the Medicaid Program Age Requirements?

Family/Children's Medicaid Program - FC/F & FC/C

To meet the dependent child requirements for Family and Children's Medicaid programs, a foster child must be under 18, or between the ages of 18 and 19 if all of the following are met:

1. The foster child is a full-time student, **AND**
2. Takes part in a program of secondary school or equivalent level of vocational or technical training (not post high school or college), **AND**
3. Expects to complete that educational program **before** reaching age 19.

Blind/Disabled Medicaid Program - BM/DM

The criteria for the Blind/Disabled Medicaid Program are the same for adults and children. No age requirement must be met.

Newborn Medicaid Program – NB

The Newborn Medicaid program covers children from birth to age 6 years. Children may receive coverage through the end of the month in which they turn 6 years old.

1. The eligibility worker must set an alert for when the foster care child turns age 6 to determine NB+ income and assets eligibility.

Newborn Plus Medicaid Program - NB+

The Newborn Plus Medicaid program covers children age 6 years and older. Eligibility begins the month after the child turns age 6 and continues through the month in which the child turns age 19.
There is no student or graduation requirement with this Medicaid program.

Prenatal & Pregnant Woman's Program - PN/PG

There is no age requirement for these Medicaid programs.

CHIP

The CHIP program is available to children until age 19. A child found eligible for CHIP will be enrolled for 12 months unless the child turns 19, moves out of state, becomes eligible for Medicaid, or is covered under another health insurance program.

PCN

Adults age 19 to 64

Foster Care Independent Living Program

Beginning July 1, 2006, individuals aging out of the foster care system can receive Medicaid from 18 until age 21 under the Foster Care Independent Living Medicaid Program. These youth must meet the following criteria:

A. 18 years old but not 21 (eligibility runs through the month in which they turn 21)
B. In foster care on their 18th birthday under State custody through DCFS or DHS with DCFS as the primary case manager, or in the custody of an Indian tribe.
C. Not eligible for another Medicaid program that does not require a spenddown or premium payment.
D. Is identified by DCFS, DHS or a tribe through electronic or written verification as someone who was in foster care on his or her 18th birthday.
E. DCFS eligibility workers will provide electronic verification. At age 18, the eligibility worker will change the PACMIS residency code to "IL". This residency code will notify BES and DWS workers that this is a youth who meets the requirements for eligibility under the FC/L program.

Medicaid Bus Pass Policy

- Children who are eligible for Foster Care or Subsidized Medicaid are eligible to receive a monthly bus pass if they live within the UTA or Cedar City Transit service areas.
- Medicaid bus passes are to be used for transportation to and from medical treatment.
- The child must be able to use the bus. Coverage for an attendant if needed is allowed for children under age 18. An authorized representative must be designated on the ADDR screen and then an asterisk will appear next to the name on the bus pass. The asterisk tells the driver that these people are allowed an attendant to accompany them.
- Bus passes have 12 one-way trips on them.
- Medicaid recipients may receive as many bus passes, as they need to obtain Medicaid-covered services from a Medicaid provider. When the client has a medical condition requiring frequent treatment and takes the bus, document this in the case record; do not verify each appointment. Update the continued medical need at each review. If a recipient makes frequent requests for more bus passes, workers may request verification of the medical need for frequent trips.
- The bus passes also work on UTA Light Rail.
- Request a monthly card on the authorization screen. Order extra cards, or cards needed only occasionally, through the CARD screen on PACMIS. *(See PACMIS section for complete directions)*
- Do not order bus passes for recipients who do not want them.
- Parents with small children who are eligible for Medicaid may request personal mileage reimbursement instead of bus passes. *(Adoption only)*
- See DOH policy 651-2 for bus passes on the website at: http://utahcares.utah.gov/infosourcemedicaid/

Medicaid Section
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When is it Income?
When is it an Asset?

Income	*Asset*
Income is cash or in-kind benefits a person receives. Count cash or in-kind benefits as income in the month a client receives it or when it is made available for the client's use. Income includes earned income and unearned income.	An asset is something someone owns that is worth money. Assets include real property and personal property. Countable assets include all assets that are available to the client and are not exempt. Any amount of the cash or in-kind benefit remaining at the end of the month is counted as an asset in the month after it is received, unless it is a type of income that has special resource exclusions. An asset includes any portion of income that remains in someone's possession after the month it is received.

An item can never be both income and an asset in the same month, *except* as specified in Medicaid policy section 511-8 relating to trusts. Most foster children will not have the type of resource described in this section. Representative Payee Accounts do not fall into these categories. If you believe a foster child on your caseload has the type of trust described in this section, please contact one of the State Specialists.

http://utahcares.utah.gov/infosourcemedicaid/

First Moment of the Month Rule

S	M	T	W	T	F	S
				1		1
2	3	4	5			8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

Disabled/Blind Medicaid Categories

503-2 "First Moment of the Month" Rule
http://utahcares.utah.gov/infosourcemedicaid/

- Use assets held on the first moment of a calendar month to compute eligibility for that month. The case is ineligible for the entire month if countable assets exceed the limit on the first moment of the month.
- Do not count anything as an asset if it is being counted as income in that month.
- Make sure that income for the month is not being counted in the asset balance.

Any Moment of the Month Rule

Family Medicaid Programs
(except Prenatal)

503-2 When Must Assets Be Below the Asset Limit?

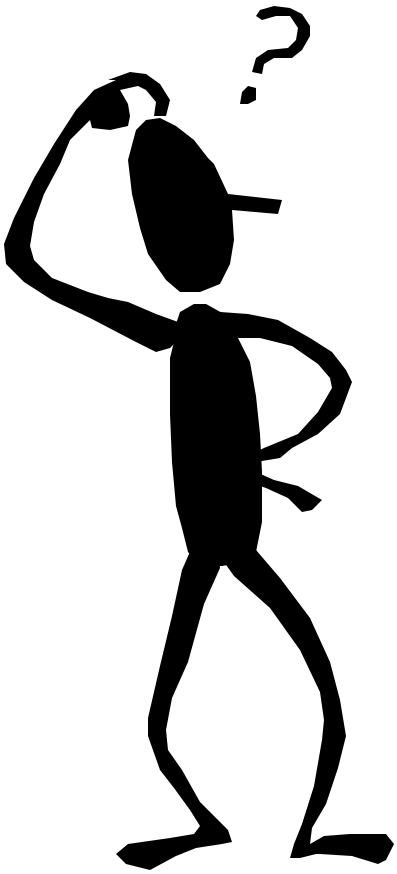
- If assets are below the asset limits at any time during the month, the client has met the asset limit rule for the entire month.
- Make sure that income for the month is not being counted in the asset balance.

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

***If using the PN program see DOH policy or contact the State Specialist.*

Lump Sum Payments For Medicaid Eligibility

Medicaid policy 407



Count the net lump sum payment as income for the month it is received. Any amount remaining after the end of that month is considered an asset.

Family Programs	Disabled Medicaid
SSA lump sum payments are exempt as an asset for **9 months** after the the month of receipt.	SSA & SSI lump sums are exempt as an asset for **9 months** after the month of receipt.

Lump sum payments are windfalls or retroactive payments of earned or unearned income. Lump sums include inheritances, settlements from personal injury suits, insurance settlements, awards, winnings, and gifts. They also include lump sums consisting of Social Security and Railroad Retirement benefits, VA lump sums, unemployment compensation lump sums, and other one-time payments. Earned Income Tax Credit (EITC) payments are NOT lump sum payments.

Remember

Cost of legal fees expended to make the lump sum available, payments for past medical bills, and funeral or burial expenses (if the lump sum was intended to cover funeral or burial expenses) are subtracted from the lump sum before determining income eligibility.

Any kind of lump sum payment of excluded earned or unearned income is excluded. If that kind of income is excluded, the lump sum payment is also excluded.

Do not count any lump sum payments received by an SSI recipient as either income or assets when determining if a child is eligible for Foster Care Medicaid.

Medicaid Section
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Prenatal Medicaid Procedures

Scenario 1- Pregnant Foster Child open for FC Medicaid

Baby removed from the mother at the time of birth and placed in State custody.

- A IV-E/Medicaid determination will be made based on the child's information.
- A Foster Care Medicaid case will be opened (or denied) in PACMIS for the child based on the child's eligibility. A new case number with the child listed as "PI" will be created.
- The child will remain open for Foster Care Medicaid as long as he/she remains eligible.

Scenario 2-Pregnant Foster Child open for FC Medicaid

The mother, who is a foster child, retains custody of the baby and the baby resides in the same foster placement as the mother.

- When the baby is born:

  - Add the PN program type to the mother's Medicaid case beginning the month of the baby's birth.
  - Add the baby to the mother's case using the child's name and date of birth.
  - The baby will be coded "IN" for the PN program and "OU" for the FC program. Code the mother "IN" for FC and "OU" for PN.
  - Use the Vital Statistics database to verify the birth.
  - A Social Security Number is required for Medicaid eligibility. Notify the caseworker to help the mother apply for a SSN as soon as possible. Coverage is allowed under the PN program for 60 days until the SSN is obtained.
  - Request TPL information for the newborn. Do not delay or discontinue Medicaid coverage for the newborn if the parent does not provide the TPL information. (TPL requirements are in Medicaid Policy Section 225)
  - Authorize the PN Medicaid for the month of birth through the current PACMI month.

- continue coverage under PN Medicaid through the month that the child turns one year old as long as the child continues to live with the mother.
- Document your actions on the CAAL screen.

Scenario 3- Pregnant Foster Child Open for FC Medicaid

The baby is placed privately for adoption at the time of birth.

- When the baby is born:

  - Add the PN program type to the mother's Medicaid case beginning month of birth.
  - Use unborn and the mother's last name for the baby's name.
  - Authorize PN Medicaid for the month of birth.
  - Close the PN program at the end of the birth month.
  - Remove the baby from the mother's case.
  - Document your actions on the CAAL screen.

**PACMIS will not recognize the Poverty level for the PN program household of two ($1422), which you may use when determining the foster child's Medic aid eligibility during the pregnancy. If you have a foster child who is pregnant and her income exceeds the NB+ level, please contact the State office for directions.

NOTE:

- ✓ **If you are using the PN program to determine Medicaid eligibility the income and assets for a household of two applies throughout the entire pregnancy and 60 days post partum.**
- ✓ **When using the PN program you look at the income and assets for the month of application (month pregnancy is verified) and then you don't consider any changes in income or assets until 60 days after the baby is born.**

DJJS PRACTICE GUIDELINES FOR ONGOING MEDICAID FOR YOUTH EXITING FOSTER CARE AT AGE 18

Purpose: To provide continued Medicaid coverage until age 19 for eligible youth who has had foster care Medicaid and is leaving state custody at age 18.

ELIGIBILITY WORKERS STEPS:

1. Identify 18-year old foster youth on caseload.

    a. Set an alert or use an existing alert for three months prior to youth's 18th birthday.

        i. Contact caseworker; in person, via e-mail or phone, for information regarding the permanency plan for the youth.
        ii. Ask to be included in child and family team meetings or case staffings, including discussions to prepare the youth to transition from custody. The eligibility worker's role and participation in CFTM's and case staffings will be determined by the individual worker and office needs.

2. Inform caseworker of the process for determining ongoing Medicaid eligibility for the youth leaving foster care and the caseworker's role in the process.

    a. Provide caseworker with ***BES Review Form 61 mr*** *approximately* 60 days prior to planned custody termination**.** Caseworker should be made aware that this form must be completed and returned to the eligibility worker 30 days prior to planned custody termination date.

        i. Request that verification of student status, income, assets and third party liability information be provided with review form. Income must be verified by interface match or hard copy. Caseworker and youth statement is acceptable verification of student status, assets and TPL information, unless the eligibility worker has reason to question that information. **Documentary evidence of birth and identity must be provided.**
        ii. Be available to answer questions from youth and caseworker.
        iii. Eligibility staff should be available for individual team trainings and staffings in their area as needed.

3. Determine which agency will review the youths continuing Medicaid eligibility.

a. Youth receiving SSI or who are pregnant or who have children. BES (or DWS if other services are also needed) will conduct the review for continuing Medicaid eligibility for these youth leaving foster care. DCFS is responsible to gather the information needed for the eligibility review and to provide this information to BES or DWS, following the procedures described in Section 4. The foster care case will not be closed prior to transfer to BES or DWS. The BES or DWS worker will close the foster care case and reopen any Medicaid program that the youth qualifies for.

b. Other 18 year old youth leaving foster care. DJJS is responsible for the Medicaid eligibility review for all 18-year old youth leaving foster care who are not receiving SSI, not pregnant, and who do not have children.

   For youth who continue to qualify for Medicaid under the NB+ program, DJJS will open the NB+ case prior to transfer to BES or DWS, as described in Section 4.

   If youth no longer qualify for Medicaid, the foster care Medicaid case will be closed, the appropriate closure reason identified in PACMIS, and an explanation documented in CAAL. Do not just use a miscellaneous closure reason and document in CAAL that the foster care case is closed. Document **WHY** the child does not qualify for Medicaid (such as whereabouts unknown, child doesn't meet eligibility criteria due to excess income or assets, etc.).

c. Determining Whether to Transfer Medicaid Case to BES or DWS. During transition planning, the eligibility worker should find out if the youth is receiving DWS services in addition to Medicaid.

   If the youth is only receiving Medicaid services, the open case will be transferred to BES via region pathway.

   If the youth is receiving additional services, such as child care, food stamps, and financial assistance, the open Medicaid case will be transferred to the DWS worker on the open PACMIS case.

4. Complete Medicaid review upon receipt of form from caseworker and transfer qualifying cases to BES or DWS.

   a. Verify receipt of necessary information.

i. Ensure that review form is complete and requested verifications have been provided. Request additional information from caseworker if necessary.
ii. Verify with caseworker the expected custody termination date.

b. Complete Review.

i. **If youth is receiving SSI, or is pregnant or has children living with them at the time of custody termination, update the address fields, and then skip to item 4.c.**
ii. For all other youth who are Medicaid eligible in foster care, two weeks prior to expected termination date, review youth's eligibility using the NB+ eligibility requirements for age, income and assets. Do not wait to do review until notification of custody termination is received.
iii. Verify with caseworker the date of actual custody termination, via phone or e-mail.
iv. **NB+ cases only:** Close the FC case in PACMIS. Use the reason XS (eligible for another program). Send applicable PACMIS notice. Document on CAAL.
v. Document on CAAL that this is a youth exiting DJJS custody and that this youth would not meet the requirements for Medicaid eligibility under the Foster Care Independent Living program (FC/L)
vi. In cases where the NB+ review showed the youth is not eligible for ongoing Medicaid, a referral to BES for CHIP eligibility should be made. Youth should be made aware of open enrollment policy for CHIP.
vii. Register NB+ case in PACMIS using the same case number as the closed FC case.
viii. Update PACMIS address fields to youth's new physical and mailing address.
ix. Complete PACMIS entry using ***NB+ PACMIS Procedures.***
x. Send appropriate PACMIS notices. MMAA for Medical Assistance approved.
xi. Document on CAAL.

c. Transfer case and case information.

i. **NB+ cases:** CARC open NB electronic case to BES or DWS worker through appropriate region pathways.

ii. **Pregnant or children in the home and SSI cases:** CARC open FC electronic case to BES or DWS worker through appropriate region pathways.
iii. Send copies of initial 61FC Medicaid application, BES Review form 61 mr; income, birth and SSN verification with the appropriate cover sheet to BES or DWS worker through appropriate region pathways. **documentary evidence of citizenship and identity must be included.**

d. File eligibility record file with closed eligibility records.

CASEWORKERS STEPS:

1. Identify 18-year old foster children on caseload.

    a. Set an alert or use an existing alert for three months prior to youth's 18th birthday

        i. Respond to eligibility worker's request for information.
        ii. Complete ***Medicaid Eligibility Review for Youth Leaving Foster Care.*** Eligibility worker will provide form 60 day prior to expected custody termination.
        iii. Caseworker is encouraged to include the youth in the review process.
        iv. Assist youth in gathering requested verifications.
        v. Submit completed review form to eligibility worker, along with requested verifications 30 days prior to planned custody termination date
        vi. Provide Eligibility worker with all information necessary to complete the review process, including an accurate physical and mailing address for the youth after custody termination.
        vii. Notify eligibility worker immediately of custody termination.

2. Familiarize youth with location of the nearest BES or DWS office.

    a. Local offices would be nearest location to expected living arrangement after custody termination.

3. Include in transition planning information to help the youth become familiar with Medicaid policies and procedures regarding Health Plans, billing by providers and mental health services.

STATE ADMINISTRATION STAFF STEPS:

1. Establish and review pathways between DHS, BES and DWS.

    a. Meet with regional BES and DWS staff.

    b. Establish pathways consisting of one or two contacts in each regional area.

    c. Type and distribute approved pathways to DHS eligibility workers and appropriate state personnel.

2. Statewide training of DHS eligibility and administrative staff.

    a. Develop a standard practice and procedure to be used by eligibility staff statewide.

    b. Distribute pathway and procedural process to regional eligibility staff and help trouble-shoot problems in pathways being effective when needed at the state level.

3. Provide on-going support and clarification for eligibility workers and regional staff.

4. Work with SAFE personnel, JJS and administration staff to develop an effective mechanism for having caseworkers follow-up on needed eligibility reviews for youth leaving care, such as an action item to be cleared by eligibility workers.

BUREAU OF ELIGIBILITY SERVICES (BES) and DEPARTMENT OF WORKFORCE SERVICES (DWS) STEPS:

1. Meet with DHS administration to establish pathways.

    a. Pathways should consist of one or two contacts in each regional area familiar with case transfers from DHS eligibility workers.

2. Approve pathways and implement within the respective regions.

    a. BES/DWS office staff should be trained on pathway and procedures.

3. BES/DWS will accept NB+ and FC cases from DHS eligibility workers.

a. In cases where the youth is receiving SSI, is pregnant or has children living with them at the time of custody termination, the BES/DWS worker will determine the ongoing Medicaid eligibility. DCFS/JJS eligibility workers will be responsible to carc the open FC case to a BES/DWS worker and send copies of information necessary for the eligibility review.

b. In cases where the youth is eligible for ongoing Medicaid using the NB+ requirements, the ongoing eligibility will be determined by the DJJS eligibility workers, FC case closed and a NB case opened. The open NB case will be card'd to a BES/DWS worker.

c. BES/DWS should contact the current DHS eligibility worker if they receive a request for services and FC Medicaid is showing as "open" on PACMIS.

DCFS PRACTICE GUIDELINES FOR ONGOING MEDICAID FOR YOUTH EXITING FOSTER CARE AT OR AFTER AGE 18.

Purpose: To provide continued Medicaid coverage for eligible youth who has had foster care Medicaid and is leaving State custody at or after age 18.

ELIGIBILITY WORKERS STEPS:

1. Identify 18 year old foster youth on caseload.

    a. Set an alert, or use an existing alert, for three months prior to youth's 18th birthday.

        i. Contact caseworker; in person, via e-mail or phone, for information regarding the permanency plan for the youth.
        ii. Ask to be included in child and family team meetings or case staffings, including discussions to prepare the youth to transition from custody. The eligibility worker's role and participation in CFTM's and case staffings will be determined by the individual worker and office needs.

2. Inform caseworker of the process for determining ongoing Medicaid eligibility for the youth leaving foster care and the caseworker's role in the process.

    a. Provide caseworker with **BES Review Form 61 mr** approximately 60 days prior to planned custody termination. Caseworker should be made aware that this form must be completed and returned to the eligibility worker 30 days prior to planned custody termination date.

        i. Request verification of student status, income, assets and third party liability information be provided with review form. Interface match or hard copy must verify income. Caseworker and youth statements are acceptable verification of student status, assets and TPK information, unless the eligibility worker has reason to question that information. **Documentary evidence of citizenship and identity must be provided.**
        ii. Be available to answer questions from youth and caseworker.
        iii. Eligibility staff should be available for individual team trainings and staffings in their area as needed.

3. Determine which agency will review youths continuing Medicaid eligibility.

a. Youth receiving SSI or who are pregnant or who have children. BES (or DWS if other services are also needed) will conduct the review for continuing Medicaid eligibility for these youth leaving foster care. DCFS is responsible to gather the information needed for the eligibility review and to provide this information to BES or DWS following the procedures described in Section 4. The foster care case will not be closed prior to transfer to BES or DWS. The BES or DWS worker will close the foster care case and reopen any Medicaid program that the youth qualifies for.

b. Other 18 year old youth leaving foster care. DCFS is responsible for the Medicaid eligibility review for all 18 year old youth leaving foster care who are not receiving SSI, not pregnant, and who do not have children.

For youth who continue to qualify for Medicaid under the NB+ program, DCFS will insure the residency code is "IL" and open the NB+ case prior to transfer to BES or DWS, as described in Section 4.

For youth who will be eligible for the Foster Care Independent Living Medicaid program, DCFS will change the Medicaid category to "L" and insure the residency code is "IL" prior to transfer to BES or DWS, as described in Section 4.

c. *Beginning July 1, 2006, individuals aging out of the foster care system can receive Medicaid from age 18 until age 21 under the Foster Care independent Living Medicaid Program. Tese youth must meet the following criteria:*

i. 18 years old but not 21 (eligibility runs through the month in which they turn 21)
ii. In foster care on their 18th birthday under State custody through DCFS or DHS with DCFS as the primary case manager, or in the custody of an Indian tribe.
iii. Not eligible for another Medicaid program that does not require a spenddown or premium payment.
iv. Is identified by DCFS, DHS or a tribe through electronic or written verification as someone who was in foster care on his or her 18th birthday.
v. DCFS eligibility workers will provide electronic verification. At age 18, the eligibility worker will change the PACMIS residency code to "IL". This residency code will notify BES

and DWS workers that this is a youth who meets the requirements for eligibility under the FC/L program.

d. Determining Whether to Transfer Medicaid Case to BES or DWS. During transition planning, the eligibility worker should find out if the youth is receiving DWS services in addition to Medicaid.

If the youth is only receiving Medicaid services, the open case will be transferred to BES via region pathway.

If the youth his receiving additional services, such as child care, food stamps, and financial assistance, the open Medicaid case will be transferred to the DWS worker on the open PACMIS case.

4. Complete Medicaid review upon receipt of form from caseworker and transfer qualifying cases to BES or DWS.

a. Verify receipt of necessary information.
   i. Ensure that review form is complete and requested verifications have been provided. Request additional information from the caseworker if necessary.
   ii. Verify with caseworker the expected custody termination date.

b. Complete Review.

   i. **If youth is receiving SSI, is pregnant or has their children living with them at the time of custody termination, update the address fields, make sure the residency code is "IL" and then skip to item 4.c.**
   ii. For all other youth who are Medicaid eligible in foster care, two weeks prior to expected termination date, review youth's eligibility using the NB+ eligibility requirements for age, income and assets. Do not wait to do review until notification of custody termination is received.
   iii. Verify with caseworker the date of actual custody termination, via phone or e-mail.
   iv. **NB+ cases only:** Close the FC case in PACMIS. Use the reason XS (eligible for another program). Send applicable PACMIS notice. Document on CAAL.
   v. Register NB+ case in PACMIS using the same case number as the closed FC case.
   vi. Update PACMIS address fields to youth's new physical and mailing address.

vii. Complete the PACMIS entry using ***NB+ PACMIS Procedures. Use the residency code IL.***
viii. Send appropriate PACMIS notices. MMAA for Medical Assistance approved.
ix. Document on CAAL.
x. **Foster Care Independent Living Cases only:** For the month following your review and the month of custody termination change the category to "L" on the PACMIS SEPA screen. **Complete the PACMIS entry using Foster Care PACMIS procedures. Use the residency code IL.**
xi. Update the PACMIS address fields to youth's new physical and mailing address.
xii. Send the appropriate PACMIS notices. MFIL for Medical Assistance approved.
xiii. Document on CAAL.

c. Transfer case and case information.

i. **NB+ and FC/L cases:** CARC open NB+ or FC electronic case to BES or DWS worker through appropriate region pathways.
ii. **For all other cases:** CARC open FC electronic case to BES or DWS worker through appropriate region pathways. Send the documents listed below to the appropriate office location.
iii. Send copies of initial 61FC Medicaid application, BES Review form 61 mr; income, citizenship, identity and SSN verification, ***with appropriate cover sheet***, to BES or DWS worker through appropriate region pathways. ***Documentary evidence of citizenship and identity must be included.***

d. File eligibility record in the family case file.

CASEWORKERS STEPS:

1. Identify 18 year old foster children on caseload.

b. Set an alert or use an existing alert for three months prior to youth's 18th birthday

i. Respond to eligibility worker's request for information.
ii. Complete ***Medicaid Eligibility Review for Youth Leaving Foster Care.*** Eligibility worker will provide form 60 days prior to expected custody termination.

iii. Caseworker is encouraged to include the youth in the review process.
iv. Assist youth in gathering requested verifications.
v. Submit completed review form to eligibility worker, along with requested verifications 30 days prior to planned custody termination date.
vi. Provide Eligibility worker with all information necessary to complete the review process, including an accurate physical and mailing address for the youth after custody termination.
vii. Notify eligibility worker immediately of custody termination.

2. Familiarize youth with location of the nearest BES or DWS office.

b. Local offices would be nearest location to expected living arrangement after custody termination.

3. Include in transition planning information to help the youth become familiar with Medicaid policies and procedures regarding HMO providers, billing by providers and mental health services.

STATE ADMINISTRATION STAFF STEPS:

1. Establish and review pathways between DHS, BES and DWS.

a. Meet with regional BES and DWS staff.

b. Establish pathways consisting of one or two contacts in each regional area.

c. Type and distribute approved pathways to DHS eligibility workers and appropriate state personnel.

2. Statewide training of DHS eligibility and administrative staff.

d. Develop a standard practice and procedure to be used by eligibility staff statewide.

e. Distribute pathway and procedural process to regional eligibility staff and help trouble-shoot problems in pathways effectiveness when needed at the state level.

3. Provide on-going support and clarification for eligibility workers and regional staff.

4. Work with SAFE personnel, JJS and administration staff to develop an effective mechanism for having caseworkers follow-up on needed eligibility reviews for youth leaving care, such as an action item to be cleared by eligibility workers.

BUREAU OF ELIGIBILITY SERVICES (BES) and DEPARTMENT OF WORKFORCE SERVICES (DWS) STEPS:

1. Meet with DHS administration to establish pathways.

    a. Pathways should consist of one or two contacts in each regional area familiar with case transfers from DHS eligibility workers.

2. Approve pathways and implement within the respective regions.

    a. BES/DWS office staff should be trained on pathway and procedures.

3. BES/DWS will accept NB+ and FC cases from DHS eligibility workers.

    a. In cases where the youth is receiving SSI, is pregnant or has children living with them at the time of custody termination, the BES/DWS worker will determine the ongoing Medicaid eligibility. DCFS/JJS eligibility workers will be responsible to carc the open FC case to a BES/DWS worker and send copies of information necessary for the eligibility review.

    b. In cases where the youth is eligible for ongoing Medicaid using the NB+ or FC/L requirements, the DCFS eligibility workers will determine the ongoing eligibility. For youth eligible for NB+ the residency code will be change to "IL", the FC case will be closed and a NB case opened. For youth eligible for FC/L, the Medicaid category will be changed to L and the residency code changed to "IL". The open NB or FC case will be card'd to a BES/DWS worker.

    c. BES/DWS should contact the current DHS eligibility worker if they receive a request for services and FC Medicaid is showing as "open" on PACMIS.

BES Pathway for Cases Received from DCFS

(for children turning 18 and leaving FC or SA)

Purpose: To provide continued Medicaid coverage, **without a lapse in coverage**, until age 19 for eligible child who has had foster care (FC) or subsidized adoption (SA) Medicaid and is leaving state custody at age 18.

Cases where FC/SA child may be eligible for NB+ Medicaid

1. DCFS social worker/youth will complete the NB+ eligibility review using BES form 61MR and forward, along with required verifications, to the DCFS eligibility worker for processing.
2. DCFS eligibility worker will close the FC/SA case (using "xs" code), send appropriate notice, and document actions on CAAL.
3. DCFS eligibility worker will complete NB+ eligibility review. If the child is not eligible for NB+, the DCFS eligibility worker must clearly document on CAAL the reason(s) why the child is not eligible.
4. If child is eligible for NB+ coverage, the DCFS eligibility worker will open NB+ (using existing FC/SA PACMIS case number) and authorize benefits. Child's new physical and mailing address will be updated, MMAA notice will be sent, and actions will be documented on CAAL.
5. Case will be carc'd to appropriate BES office using region pathway information.
6. Copies of Medicaid application, Medicaid eligibility review for youth leaving foster care or subsidized adoption, 61MR, income, birth verification will be sent to appropriate BES office.
7. BES supervisor receives case.
8. Supervisor or assigned worker reviews case to ensure accuracy and that the appropriate program was determined/authorized.
9. Supervisor or assigned worker contacts child to complete HMO orientation.

Cases where FC/SA child is SSI recipient, or is pregnant or has child(ren)

1. DCFS social worker/youth will complete the eligibility review using BES form 61MR and forward, along with required verifications, to the DCFS eligibility worker.
2. DCFS eligibility worker will leave the FC/SA case open and notify the appropriate BES worker via E-mail of child's circumstance. Actions will be documented on CAAL.
3. DCFS eligibility worker will send copies of any necessary information, including completed 61MR, to BES worker and carc the open FC/SA case to appropriate BES office using region pathway information. Actions will be documented on CAAL.
4. BES supervisor receives case and assigns to BES eligibility worker.
5. BES eligibility worker will close FC/SA case (using "xs" code) and determine eligibility using appropriate program type. Actions will be documented on CAAL.

6. BES eligibility worker will open and authorize appropriate program type (using existing FC/SA PACMIS case number). Notice(s) will be sent, and actions will be documented on CAAL.
7. BES eligibility worker will contact child to complete HMO orientation.

Cases where FC/SA child is receiving supportive services through DWS

1. DCFS social worker/youth will complete the eligibility review using BES form 61MR and forward, along with required verifications, to the DCFS eligibility worker.
2. If the child is receiving additional services, such as child care, food stamps or financial assistance, the DCFS eligibility worker will leave the FC/SA case open and notify the appropriate DWS worker via E-mail of child's circumstance. Actions will be documented on CAAL.
3. DCFS eligibility worker will carc the open FC/SA case to the appropriate DWS office.
4. DWS eligibility worker will close FC/SA case (using "xs" code) and determine Medicaid eligibility using appropriate program type. Actions will be documented on CAAL.
5. DWS eligibility worker will open and authorize appropriate program type (using existing DWS PACMIS case number). Notice(s) will be sent, and actions will be documented on CAAL.
6. DWS eligibility worker will refer child to appropriate Managed Health Care HPR to complete HMO orientation.

Keys to Medicaid Closures after Age 18

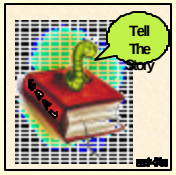
Closure Codes

Use the correct closure code in PACMIS. If you haven't received the information from the caseworker, please close the case using the IV code. If denying for income, make sure the income is posted on the PACMIS screens and use the closure code GI. If denying for assets, make sure the assets are posted in the PACMIS screens and use the closure code AL. IF child is a runaway use the closure cold UL. Check the PACMIS Quick Reference for a complete list of closure codes.

Document, Document, Document!!!!!

PACMIS CAAL logs must contain the details of the FC closure and NB+ determination.

Tell the Story!



Send the Closure Notices from PACMIS.

Notice of Medicaid case closure is a Medicaid requirement. The case is in error if the notice is not sent at case closure. See the PACMIS Quick Reference for a complete list of notices.

Independent Living Medicaid Program

Youth exiting Foster Care at or after age 18 can be eligible for Independent Living Medicaid until age 21 with no income or asset test. IL Medicaid is the last program of choice after all other program eligibility has been eliminated. Follow the established practice guidelines for continued Medicaid eligibility and case transfer to BES or DWS.

Department of Health-BES
Pathways
Updated October 2006

County/Location-Zip Code	Contact Person/Supervisor		Mailing Address	Phone Number
Uintah	Jacoy Richins	Judy Spigarelli	Department of Health/BES 140 W 425 S Roosevelt, Ut 84066	435-722-6520
Daggett	Jacoy Richins	Judy Spigarelli	Department of Health/BES 140 W 425 S Roosevelt, Ut. 84066	435-722-6520
Duchesne	Jacoy Richins	Judy Spigarelli	Department of Health/BES 140 W 425 S Roosevelt, Ut. 84066	435-722-6520
Carbon	Judy Spigarelli		Department of Health/BES 475 W Price River Drive Price, Ut 84501	435-636-0227
Emery	Judy Spigarelli		Department of Health/BES 475 W Price River Drive Price, Ut 84501	435-636-0227
Grand	Judy Spigarelli		Department of Health/BES 475 W Price River Drive Price, Ut 84501	435-636-0227
San Juan	Judy Spigarelli		Department of Health/BES 475 W Price River Drive Price, Ut. 84501	435-636-0227

County/Location-Zip Code	Contact Person/Supervisor	Address	Phone Number
Juab	Darren Fox	Department of Health/BES 150 E Center, Suite 3100 Provo, Ut 84606	801-374-7830
Sevier	Ilene Dunn	Department of Health/BES 201 E 500 N P.O. Box 399 Richfield, Ut 84701	435-896-1223
Millard	Ilene Dunn	Department of Health/BES 201 E 500 N P.O. Box 399 Richfield, Ut 84701	435-896-1223
Piute	Ilene Dunn	Department of Health/BES 201 E 500 N P.O. Box 399 Richfield, Ut 84701	435-896-1223
Garfield	Ilene Dunn	Department of Health/BES 201 E 500 N P.O. Box 399 Richfield, Ut 84701	435-896-1223
Wayne	Ilene Dunn	Department of Health/BES 201 E 500 N P.O. Box 399 Richfield, Ut 84701	435-896-1223
Beaver	Ilene Dunn	Department of Health/BES 201 E 500 N P.O. Box 399 Richfield, Ut 84701	435-896-1223

County/Location-Zip Code		Contact Person/Supervisor	Address	Phone Number
Kane		Mike Dunlavy	Department of Health/BES 619 S Bluff St, Suite 4A St. George, Ut 84770	435-688-0489
Washington		Mike Dunlavy	Department of Health/BES 619 S Bluff St, Suite 4A St. George, Ut 84770	435-688-0489
Iron		Ilene Dunn	Department of Health/BES 201 E 500 N P.O. Box 399 Richfield, Ut 84701	435-896-1223
Utah	Provo	Darren Fox	Department of Health/BES 150 E Center, Suite 3100 Provo, Ut 84606	801-374-7830
Utah	North County	Carolyn Evans	Department of Health/BES 953 E 900 N American Fork, UT	801-763-4182
Utah	South County	Clint Gray	Department of Health/BES 150 E Center, Suite 3100 Provo, Ut 84606	801-374-7765
Wasatch		Carolyn Evans	Department of Health/BES 953 E 900 N American Fork, UT	801-763-4182
Summit		Carolyn Evans	Department of Health/BES 953 E 900 N American Fork, UT	801-763-4182

County/Location-Zip Code	Contact Person/Supervisor	Address	Phone Number
Davis	Kathy Adams	Department of Health/BES 915 N 400 W, Ste 201 P.O. Box 650 Layton, Ut 84041-0650	801-444-2902
Box Elder	Scott Hawkes	BES Logan Office 115 W Golf Course Rd. Suite A Logan, Utah 84321	435-787-3556
Cache	Scott Hawkes	BES Logan Office 115 W Golf Course Rd. Suite A Logan, Utah 84321	435-787-3556
Rich	Scott Hawkes	BES Logan Office 115 W Golf Course Rd. Suite A Logan, Utah 84321	435-787-3556
Weber	Lana Adams	BES,Ogden Regional Center 2540 Wahington Blvd P.O. Box 349 Ogden, Ut 84402-0349	801-626-3162
Morgan	Lana Adams	BES,Ogden Regional Center 2540 Wahington Blvd P.O. Box 349 Ogden, Ut 84402-0349	801-626-3162

County/Location-Zip Code		Contact Person/Supervisor	Address	Phone Number
Tooele	Wendover 84083	Shirlene Bingham	Department of Health/BES 6671 S Redwood Rd. Ste 110 West Jordan, Ut 84084	801-270-1325
Salt Lake	84101 84102 84103 84104 84105 84106 84108 84109 84111 84112 84113 84114 84115 84116 84117 84121 84124 84020 84047 84070 84090 84091 84092 84093 84094	Kathy Cordova	Department of Health/BES 660 S 200 E #440 Salt Lake City, Utah 84111	801-236-6795

County/Location-Zip Code		Contact Person/Supervisor	Address	Phone Number
Salt Lake	84107 84171	Teri McPhail	Department of Health/BES 7292 S State Midvale, Ut 84047	801-567-3853
Salt Lake	84006 84044 84065 84084 84088 84095 84096 84119 84120	Shirlene Bingham	Department of Health/BES 6671 S Redwood Rd. Ste 110 West Jordan, Ut 84084	801-270-1325
Tooele	84022 84029 84034 84069 84071 84074 84080	Shirlene Bingham	Department of Health/BES 6671 S Redwood Rd. Ste 110 West Jordan, Ut 84084	801-270-1325

Ongoing Medicaid Coverage for Foster Children Leaving Custody to a Non-Relative Guardianship Placement

- DCFS Practice Guidelines are located on the web at http://www.hspolicy.utah.gov/dcfs/. Policy regarding guardianship is in Section 308.2.

- The permanency worker is responsible to notify the eligibility worker that guardianship is the child's permanency plan and the approximate date for custody to be terminated. This will help ensure that Medicaid coverage can continue without interruption for an eligible child. The permanency worker will also let the eligibility worker know if a guardianship subsidy is planned for the child.

- The eligibility worker will provide the permanency worker with a Medicaid review form (61MR) to be completed prior to termination of DCFS custody.

- The permanency worker will work with the prospective guardian to complete the review form within 30 days prior to guardianship being granted by the court. The guardians name and address must be specified on the form. Income and asset information for the child will be reported on the form.
  - ✓ A guardianship subsidy payment is considered countable income for the child for family Medicaid programs. For blind or disabled Medicaid programs, the guardianship subsidy is not considered countable income for the child.

- The permanency worker is responsible to provide the eligibility worker with the following information soon after the court has granted custody and guardianship but before the SCF case is closed in SAFE:
  - ✓ Completed Medicaid review form.
  - ✓ Copy of Guardianship Subsidy Agreement (if applicable).
  - ✓ Copy of court order terminating DHS/DCFS custody.

- The eligibility worker will review the child's Medicaid eligibility and take the appropriate action as outlined below:
  - ✓ When the eligibility worker is notified that the SCF case has closed and guardianship has been given to a non-relative caretaker (usually the foster parent), the child's case will be reviewed for ongoing Medicaid eligibility using NB+ Medicaid eligibility requirements. To be eligible for a DCFS non-relative guardianship, the child must be at least 12 years of age.
  - ✓ Complete a Medicaid review for the child and if the child meets the requirements for NB+ eligibility do the following:
    - Close the FC Medicaid case and open a NB case in PACMIS using the same case number.
    - Document all of your actions on the CAAL screen.
    - Send the appropriate closure notice.

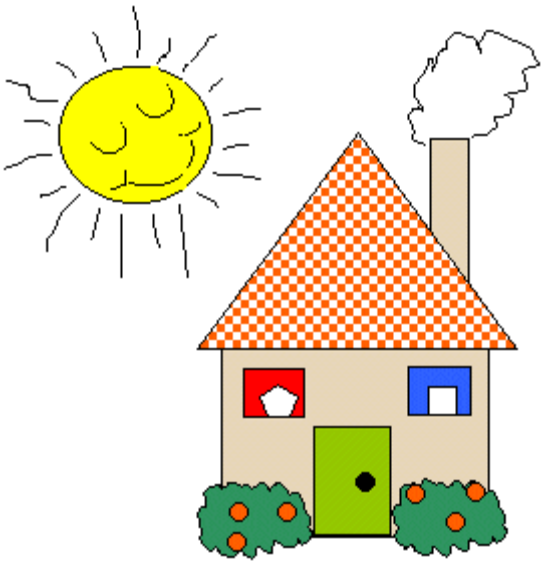
- Transfer the case to the appropriate BES office via the established pathways. This includes carc'ing the electronic PACMIS case and sending copies of all relevant documents. The relevant documents include a copy of the IV-E/Medicaid application (61FC), copy of birth verification, Social Security Number, copy of the guardianship subsidy, copy of the court order granting custody to the guardian and any income and asset verifications.

✓ If the child is receiving SSI or is pregnant, leave the FC case open, change the address on the ADDR screen (if necessary) and send the information listed above to BES through the established pathways. BES will close the FC case and open the appropriate Medicaid program for the child.

✓ If the child does not meet the requirements for NB+ Medicaid eligibility, close the FC case and document the decision clearly on the CAAL screen. Include any income and asset information on the appropriate PACMIS screens. Send the appropriate closure notice.

✓ **In cases where there is more than one sibling in a guardianship placement, BES will manage those cases on one case. Leave the FC cases open and transfer the information to BES through the pathways. BES will close the FC Medicaid cases and open one case with all the siblings included.**

Independent Living Youth



- Independent living payments paid to the foster child are countable unearned income for Medicaid eligibility, unless the child is receiving SSI.
  - Income of an SSI recipient is not countable for Medicaid purposes.
  - Payment codes include ILP, TLN and TLP.
- When the monthly income, including IL payments, exceeds the income limit of the Medicaid program; the child is not Medicaid eligible for that month.
  - Children's Medicaid program - Basic Maintenance Standard $382.
  - NB+ Medicaid program - 100% of Poverty Level.
  - PN Medicaid program - 133% of Poverty Level.
  - Disabled Medicaid program - 133% of Poverty Level.
- BAB payments are countable income to the child of the foster child.
- Independent living youth who are over 18 and were in the custody of DHS/DCFS on their 18th birthday can be eligible for Foster Care Independent Living Medicaid while still in custody.

PACMIS Notices

- **Medicaid policy requires that proper notice of action taken on a Medicaid case be sent to the applicant or recipient. Notices must be sent when an application is approved and when benefits are denied or changed.**
  - **DOH Policy 811- "The agency must provide all recipients with a written notice of any action that affects the amount, form or requirements of the assistance. Written notice includes an explanation of the action, the reason for the action, a citation of the regulation upon which the action is based, the effective date of the action, and the phone number for the local office to contact for any additional information."**
- **10*10*10 Rule**
  - **The 10*10*10 Rule says that a Medicaid household must report a change within 10 calendar days from the date of the change, the agency has 10 calendar days to take action on the reported change, and the agency must provide a 10 day advance notice of a negative action.**
  - **If 10 day notice cannot be provided, make the change effective the following month.**
  - **A worker shall take action on a change as soon as possible, but no later than 10 days after the change is reported or discovered.**
- **The PACMIS Quick Reference, Section 6 contains a list of notices available for Medicaid actions.**
  - **GIFF notices are not acceptable as a notice of action on a Medicaid case. A GIFF is an informational notice and not intended for use as a case action notice.**

Medicaid Eligibility for Children Placed in DCFS Custody through a Voluntary Placement Agreement

- DCFS may apply for Medicaid benefits for a child placed into State custody through a Voluntary Placement agreement.

Factors to Consider

- A Voluntary Placement Agreement is in place, DCFS has care and placement responsibility and the placement is receiving a Foster Care Maintenance payment.

- **The household size, income and assets of the parents must be considered when determining Medicaid eligibility if the child is not IV-E eligible.**

Establishing a Disability Through the State Medicaid Disability Office

- A child can remain eligible for disabled category Medicaid for up to one year after SSI benefits have terminated. After 1 year, a disability will have to be established through the State Medicaid Disability Office to continue eligibility for the disabled Medicaid program.

- Have the client complete a Medicaid Disability Application (Form 354) or help the client complete the form. Make sure the information is complete and accurate. Disability Review forms are available on the EOL website at http://health.utah.gov/eol/forms/forms.html

- Have the client sign several 114H release forms. The client must cooperate and assist the eligibility worker in getting the needed medical evidence. Some clients may not be able to get the medical evidence they need to support their claim because of physical and/or mental impairments, or because of language or cultural barriers. Eligibility workers need to help clients, as needed, get the forms and evidence needed to support a disability finding.

- After gathering the necessary medical evidence, send the following information packet to the Medicaid Disability Examiner:
  - ✓ **Request for Medicaid Disability Decision.** the top half of the form must be completely filled out by the eligibility worker.
  - ✓ **Medicaid Disability Application.** The worker must complete page four. The client or the representative must complete the rest of the form. (Workers may need to help clients complete the form.)
  - ✓ **Physical Impairment/Disability Report.** The treating physician or therapist must complete and sign this form.
  - ✓ **Mental Status Report (if applicable).** The treating physician or therapist must complete and sign this form.
  - ✓ **Any other evidence as described in DOH policy Section 303-3.**
  - ✓ Send the packet to Utah Department of Health, Attn: Jack West, P.O. Box 14010, SLC, Ut., 84114 or use a State Mail routing slip.

- If you have any questions about what information is needed for a specific impairment, what specialist to use, or other questions about the Medical Disability determination process, call the State Medicaid Disability Office at 801-538-6480.

- Complete DOH procedures to establish a disability through the State Medicaid Disability Office are available on the DOH policy website in Section 303-3. http://utahcares.utah.gov/infosourcemedicaid/

Medicaid Applications

- An application for Medicaid consists of the following:
  - A completed and signed application form.
  - All applications must have an original signature. A signed application sent by fax is treated as an original signature.
  - If an application is received without a signature, a signature will need to be obtained.
  - An application for Medicaid may be submitted in person, by mail, by fax or by phone, or online via the Internet, if available.

- Every Medicaid application must be date stamped on the date that it is received.
  - The date of application must be established to determine when medical assistance coverage can begin. Retroactive coverage is based on the date of application and the date the individual met the eligibility criteria.
  - Every Medicaid application that is received must be registered in PACMIS. Appropriate action to approve or deny that application must be taken.

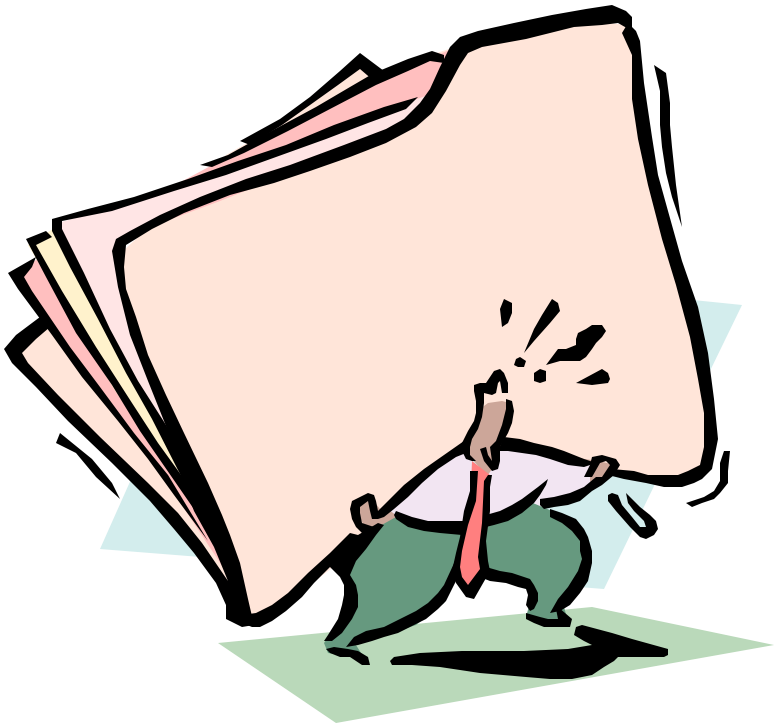
- The eligibility worker must make an eligibility decision with 30 days of the date of the application. There is one exception: if the applicant is claiming to be disabled, a decision must be made within 90 days of the date of the application.
  - If a decision cannot be made before the deadline, document the cause of the delay in the case record.

- An applicant must apply for assistance and sign the application form in his own behalf unless he is unable to do so because he is a minor or because of incapacity that prevents him from completing the application process. If the applicant is a minor, the applicants parent, legal guardian, or representative must sign the forms.

- When DCFS/DJJS has custody of a child and the child is placed in foster care, the division with custody will complete the application process.
  - The Medicaid application must be signed by the child's caseworker.

- Record the eligibility decision on the CAAL screen.
  - If the application is approved, indicate the date and the medical assistance programs approved for the household members. Narrate your decision clearly.
  - If the application is denied, note the date and the reason for the denial.

- When the application is approved or denied, notify the applicant in writing of the approval or denial.
  - If the client must pay for coverage, explain this in the notice and how and where payment can be made. The notice must give the citation that covers the reason for a payment.
  - If the application is denied, state the reason for the action and give the policy citation for the denial reason.
  - Tell the client where to call if the client has questions or concerns.
- Set alerts on the case to control for changes that are expected to occur before the next review, or for actions that should be taken for the next review.



Detention Placements

- **Was the foster child court ordered to spend time in detention?**

No	Yes
Medicaid Policy 215-3 **Who is a Resident of an Institution?** A child living in an institution is a resident of that institution. One exception applies to all kinds of institutions: a child in the custody of the State is not a resident of an institution if he is: 1. Under age 18, AND 2. In the custody of a State agency, AND 3. Living temporarily in an institution while arrangements are being made for an appropriate placement. Foster children may be put in a detention center while authorities decide where they should be placed. These children are not residents of the detention center. A foster child who is placed in detention, but has not been ordered by the court to stay in detention, remains eligible for Medicaid during the detention placement.	**Medicaid Policy 215-2** **Who is a Resident of a Household?** A person living in a household is a resident of that household. **Medicaid Policy 216-6** **Residents of Non-Medical Institutions.** Non-medical institutions include jails, prisons, and community residence facilities. Other institutions may also be non-medical. Medicaid policy differs for residents of public or private non-medical institutions. A public institution is the responsibility of a governmental unit. Juvenile detention centers are public non-medical institutions. Residents of most public, non-medical institutions are not eligible for Medicaid. Foster children who have been court ordered to stay in detention are not eligible for Medicaid while they are staying in the detention center. Once a person becomes a resident of a public non-medical institution, he must continue to be considered a resident of a public institution until released from the facility. If a person "escapes" from the or if a person leaves and is supposed to return when the purpose for the absence ends (medical treatment) institution he has not been released. A foster child who is court ordered to spend time in detention is not eligible for Medicaid while staying at the detention facility. Medicaid eligibility can begin again when the foster child leaves detention and is placed in an eligible foster care placement providing they meet all the other FC Medicaid eligibility requirements.

Dedicated Accounts

Lump Sum SSI Payments

When a minor child receives an SSI lump sum payment for retroactive months' benefits, in excess of 6 months of benefits, the Social Security Administration requires the child's representative payee to establish a **"dedicated account"** to receive and maintain such payments.

The payee may also deposit subsequent SSI lump sum payments that equal or exceed one month's benefits into the dedicated account.

Medicaid Policy 531-2

Excluded Resource

The dedicated account will be an excluded resource for Medicaid purposes as long as the account is maintained according to SSA's requirements for such accounts. In addition, income earned on these funds is excluded from income.

If the individual with a dedicated account is no longer receiving an SSI payment, the dedicated account becomes a countable asset the month after the person becomes ineligible for SSI.

Specific Expenses

The funds in dedicated accounts can only be used for specific expenses related to the impairment of the child. The funds cannot be used to reimburse the cost of support and maintenance of the SSI recipient. The allowed uses are as follows:

- Education or job skill training.
- Personal needs assistance.
- Special equipment or housing modifications.
- Medical treatment, therapy or rehabilitation.
- Other items or services, which SSA determines are appropriate.

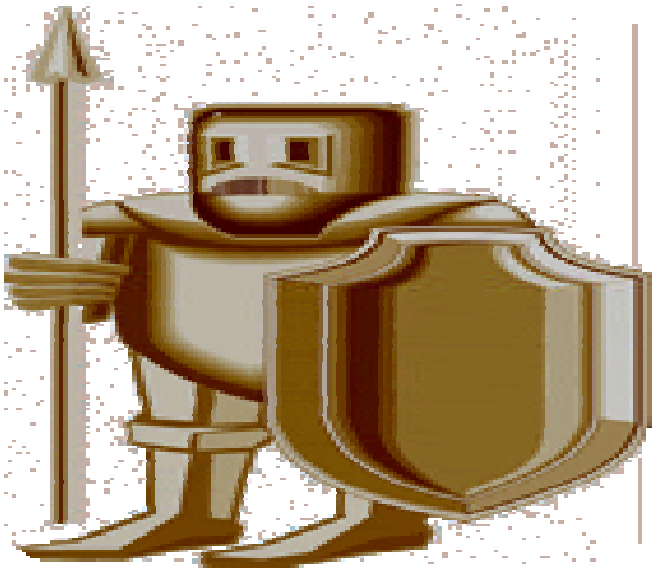
The representative payee will be required to report to SSA on the use of these funds.

Assets Managed by a Guardian, Conservator, Representative Payee or Other Responsible Person

Medicaid Policy 511-2

- The assets of a foster child that are managed or controlled by a legal guardian, a conservator, a representative payee or some other responsible person acting for the client are available resources of the child, and the asset is countable for Medicaid purposes. This is true even if the child does not live with the person managing the assets. The child does not have to have the physical or mental ability to access the assets; the assets are still treated as assets belonging to the child.

- The assets do not belong to the person managing them, because that person is obligated to hold and use the assets for the benefit of the child. The person managing the child's assets is not to use the assets for his own benefit.



Trusts

Medicaid Policy 511-8

- Medicaid policy and rules regarding trust funds are **very complex**. The availability of assets from a trust is viewed differently depending on when the trust was established. There are two periods of time that you must look at: Trusts established before August 11, 1993, and trusts established on or after August 11, 1993.
- Assets from trust accounts are viewed differently depending on the Medicaid program you are basing eligibility on. The policy for family or children's categories differs from the policy for blind and disabled categories.
- **Revocable Trust:** A trust, which can be terminated by the grantor. A trust is also considered revocable if a court can modify or terminate it, because the client can petition the court to terminate the trust. In addition, a trust that is called "irrevocable" but which terminates if the grantor takes some action, is considered revocable.
- **Irrevocable Trust:** A trust is considered irrevocable when the grantor cannot, in any way, terminate the trust.
- Medicaid eligibility for a foster child with a trust account must be reviewed with the State Specialist prior to approving Medicaid eligibility.
- If a determination of availability cannot be made, a copy of the trust agreement must be sent to the DOH program specialist for a decision. Include a cover page with the client's name, date of application, Medicaid program applying for, whose funds were used to establish the trust, and other pertinent information.

Request to have Document Reviewed

TO: **Zandie Leffler (fax # 801-538-6952)**

Client Name: _____

Client ID: _____

Category of Assistance Being Considered: _____

Type of Document: _____

Date: _____

Total Pages in the document: _____

What is the specific question that needs to be answered?

_____

_____

_____

Reply to

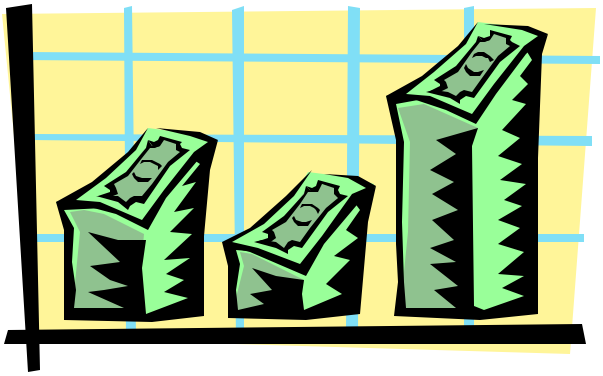
_____

Worker Phone DRO

Re: Any Document that you want to have reviewed by a Policy Specialist (ie: trusts, annuities, sales contracts, burial contracts, life insurance policies, etc.)

Effective immediately, all of these documents are to be sent to Zandie Leffler. Zandie is the same person who gets the packets of information that are for review by the Medical Review Committee. She will assign the document to the policy specialist for the program which is being considered. Once a decision is made, the policy specialist will contact the requester with the results of the review. At the same time they will notify Zandie that the review is completed. This will allow us to better track the status of these requests. Imaged Documents, can be e-mailed directly to Zandie. For hard copies, the worker should mail or fax a copy (never originals) to Zandie. Her fax # is 538-6952. The attached cover sheet must accompany any request to have a document reviewed.

What is Income?



Income is cash or in-kind benefits a person receives. Income includes earned income and unearned income. In-kind income is not cash. It is something other than cash that a person receives.

- Count cash or in-kind benefits as income in the month the foster child receives it or when it is made available for their use.

- Any amount of the cash or in-kind benefit remaining at the end of the month is counted as an asset in the month after it is received.

- Workers must identify a child's total monthly income. The total income is used to determine the child's countable income for Medicaid eligibility, and to calculate a spenddown if applicable.

Countable Earned Income	Countable Unearned Income
Wages and Salaries	Interest and dividends
Living allowance stipend	SSA survivors or retirement benefits
Training incentive payments	IL payments made to the foster child
Work allowances	Cash gifts
Severance pay	BAB payments made for the child or a foster child

Earned Income Exclusions	Unearned Income Exclusions
Earned income of a dependent child	All unearned income of an SSI recipient
All earned income of an SSI recipient	FEP

Medicaid Spenddowns
Things You Need to Know

- Medicaid policy requires that ongoing Medicaid recipients must pay their spenddown by the 10th of the month following the benefit month. Otherwise the case must be closed and the client must reapply.

- The medical expenses for a child must exceed or are expected to exceed the amount of the spenddown for the month.

- The eligibility worker is responsible to authorize the payment of the spenddown each month. A spenddown form, authorizing the payment, must be received from the eligibility worker **each month**.

- Spenddowns must be paid before cost of care.

- A child receiving SSI is not be required to pay a spenddown. The incomeof an SSI recipient is not countable for Medicaid purposes.

- Spenddowns should be paid immediately following the receipt of the spenddown form whenever possible. There is no Medicaid benefit for the month until the spenddown has been cleared. Healthcare costs for a child with a spenddown must be paid in another way while waiting for a spenddown to clear.

- When a spenddown is paid after the 15th of the month, TCM services are not directly billed because the child is considered to have not been eligible for Medicaid for that month. TCM must be back billed when spenddowns are paid after the 15th. As of December 31, 2005 all TCM billing has been discontinued.

- Income limit for a child ages 6-19 is 100% of poverty level.

- Income limit for a child ages 0-5 or pregnant teen is 133% of poverty level.

- When the child's income exceeds the limits a spenddown must be made to the Medicaid BMS of $382.

Medicaid Spenddown Helpful Hints

Determination Factors

- ✓ Countable Income over the BMS of $382.00 is used for calculating the need and amount of the spenddown. SSI income is not countable. Spenddowns are allowed for Children, Pregnant Women, Blind, and Disabled Medicaid categories. Spenddowns are not allowed for IV-E, Newborn, Newborn Plus or Pre Natal Medicaid categories.
    - If a child receives a monthly SSA benefit of $834.00, they must spenddown to the $382.00 level. The spenddown amount would be $452.00. A spenddown cannot be made to NB or NB+ income level.
- ✓ PACMIS entry is the same as for all Foster Care Medicaid cases. Make sure to post the countable earned and unearned income. PACMIS will automatically calculate the spenddown amount. Notice type is MMEX. Document determination on CAAL.
- ✓ Medical expenses must exceed the cost of the spenddown each month.
    - Medicaid reimbursement for treatment portion of placement can be counted as part of the medical expenses.
    - SFD rate and "D" code placements have treatment costs associated with the placement.
    - TCM rate can also be counted as part of the medical costs. The TCM rate from Oct 2004 to Sept 2005 was $485.82. This rate is subject to review and change yearly. The TCM rate for Oct 2005 to Sept 2006 is $494.48. For dates of services after December 31, 2005, all TMC has been discontinued.
    - Prior medical expenses for a Medicaid client can be viewed in MMIS.

Procedure

- ✓ Notify Caseworker of required spenddown.
- ✓ See **Medicaid Spenddown Process**.
- ✓ Linda O'Brien will notify you when the Medicaid card can be mailed to the provider. When a spenddown has been cleared, PE will show in the DOC STA field on the MEBH screen. Document on CAAL that spenddown has cleared and card has been mailed.
- ✓ Policy requires that Medicaid cards for cases with spenddowns be mailed to the local DWS/BES business office. The business office personnel may forward the cards to the eligibility worker. If the eligibility worker does not receive the Medicaid card, you may do one of two things.
    1. Contact the DWS/BES business office and ask them to mail the Medicaid card.
    2. Order a new Medicaid card on CAMM. This card will mail directly to the placement because the spenddown has been paid.
- ✓ An MI-706 may be issued to provide coverage until the spenddown process is complete and the card can be issued.
- ✓ Spenddowns must be cleared by the 10th of the month following the eligibility month or the PACMIS case should be closed. Policy 415-7 goes over the time limit for meeting spenddowns. This policy is also covered in a Clarification dated February 10, 2003.

MEDICAID SPENDDOWN PROCESS

DCFS

-Make sure benefit month shows on the MEBH for the month you are paying spenddown.
-Print the MEBH screen.
-Hightlight the benefit month and the amount of the spenddown for that month.
-Fill out the DCFS Medicaid Spenddown form, making sure to fill in all areas.
-Forward to Representative Payee Account Technician.
-Representative Payee Account Tech will cut a check, fill in the "Date sent to State Office" and mail.

*Check is mailed to Linda Moon.
*Linda will query SAFE and PACMIS to verify child's SCF eligibility and spenddown amount.
*Linda Moon will notify Linda O'Brien to clear spenddown
*Linda O' Brien will forward check and spenddown information to DCFS Finance, Judy Chan.

-DCFS Finance will deposit check and do IAT transfer to ORS.

*Judy coordinates with Joe Torres at ORS.

DJJS

-Make sure benefit month shows on the MEBH for the month you are paying spenddown.
-Print the MEBH screen.
-Highlight the benefit month and the amount of the spenddown for that month.
-Fill out the DJJS Medicaid Spenddown form, making sure to fill in all areas.
-FAX to ORS to Kari Smith for Representative Payee Account procedure process.

*Kari coordinates the ORS process with Mike Tazelaar

-FAX to Linda Moon.
-ORS will notify Linda O'Brien to clear spenddown.

PACMIS SPENDDOWN SCREEN

-On payment screen, Linda O'Brien enters "Y" for paid, the date that the check was deposited by DCFS Finance or ORS, and whether it was "cash" or "check", then authorizes it with her PCN number.
-Linda O'Brien will send notification to Caseworker, Eligibility Worker and Representative Payee Account Tech that spenddown has been cleared and that Medical Card can be released.

EXMC EXCESS MEDICAL CARD PAYMENT 13FEB03 10:48
LINDA O

CASE NAME: POTTER, HARRY CASE NUMBER: 00999999

BENEFIT MONTH: FEB03

PROG TYPE	MEDICAL EXCESS	PRIOR EXPENSES	CURRENT EXPENSES	IS RS	CASH PAYMENTS	REMAINING EXCESS	PD ID	DATE PAID	CSH CHK
FC	399.00	0.00	0.00	RE	0.00	399.00	__	_____	___

WORKER AUTHORIZATION: ____ NEXT-->

Spenddown Worksheet

Suzy Q is removed from the custody of her mother and placed in DCFS custody by court order on Oct 27, 2004. The eligibility worker has determined that Suzy is not IV-E eligible because the income of the AFDC group exceeds the IV-E need standards. Suzy receives monthly SSA income because her father is deceased. The amount of her SSA check is currently $974.00 monthly. Suzy has no assets.

Is Suzy eligible for Foster Care Medicaid?

_____ Yes
_____ No
__X__ With a spenddown

Spend Down Calculation

Child Countable Income	$ _____
Minus Program Income Limit	$-_____
Total Spend Down Amount	$ _____

On Oct 27, 2004 Suzy is placed at the Christmas Box House (SHN). She is moved to a structured foster home on Nov 13, 2004 (SFD). She remains in that foster home until Jan 3, 2005, when she is moved to a residential treatment placement (DLR). She remains in this placement.

What is the Medicaid treatment costs associated with Suzy's placement for:

October 2004 **$O**
November 2004 **$279,82**
December 2004 **$510.26**
January 2005 **$1631.71**
February 2005 **$1527.68**

MMIS indicates that following total expenditures for Suzy: (not including any placement associated treatment costs or TCM billings)

October 2004	$ 275.00
November 2004	$ 303.00
December 2004	$ 978.00
January 2005	$10,062.00
February 2005	$ 97.00

TCM's were billed by the division for Nov & Dec 2004 and Jan & Feb 2005.

Which months did the Medicaid related expenses exceed the spenddown amount?

_____ Oct 2004 _____ Nov 2004 **X**____ Dec 2004
X____ Jan 2005 **X**____ Feb 2005

DCFS MEDICAID SPENDDOWN FORM

To: Linda Moon
DCFS Federal Revenue Team
120 North 200 West
Suite 235
Salt Lake City, Utah 84103

Caseworker	Eligibility Worker	Representative Payee
Phone #	Phone #	Phone #

Child's Name	
Child's Social Security Number	
Child's Client ID Number	
PACMIS Case Number	
Month/Year Spenddown Applies To:	Amount:

Date Sent to State Office:

Date Received at State Office:

Date Sent to ORS:

Date Spenddown Cleared:

DJJS MEDICAID SPENDDOWN FORM

To: **ORS/Kari Smith**
DCFS/Linda Moon

Eligibility Worker	Caseworker
Phone #	Phone #

Child's Name	
Child's Social Security Number	
Child's Client ID Number	
PACMIS Case Number	
Month/Year Spenddown Applies To:	Amount:

Date Sent to ORS:

Date IAT Cleared:

Date sent to DCFS:

Date Spenddown Cleared:

Emergency Medicaid

Rule of Thumb

If a procedure can be scheduled in the future the service will rarely qualify as an emergency.

Medicaid Policy 205-6

- Emergency Medicaid is not a separate type of Medicaid. Emergency Medicaid provides coverage for only emergency services to individuals who meet all the requirements for a Medicaid program but are not a U.S. citizen or qualified alien.

- Who may be eligible?
  - ✓ Any alien who does not meet the alien status requirement to be eligible for full Medicaid coverage may be eligible for Emergency Medicaid.
    - Undocumented aliens.
    - Aliens who are in the country legally but are not qualified aliens.
    - Qualified aliens who are barred from Medicaid for 5 years.
    - Citizens of Freely Associated States who meet state residency requirements.

- To be eligible for Emergency Medicaid, the individual must indicate that he or she has received emergency service in the application month or retro period, or is currently in need of emergency medical services. The eligibility worker does not need to determine if Emergency Medicaid will cover the services. All claims for Emergency Medicaid cases are reviewed by Medicaid Operations to determine if the service meets the criteria for coverage under Emergency Medicaid.
  - ✓ **Do not deny Emergency Medicaid because you suspect there is not an emergency medical need.**

- The applicant must meet all other Medicaid eligibility rules except Social Security Number.

- ✓ The individual must meet the eligibility requirements for a Foster Care Medicaid program.

✘ Register the FC program type with then post an "E" in the coverage group field (FC-E).

✘ Use the following PACMIS notices for Emergency Medicaid.

- ✓ Approval notice - MEEA.
- ✓ Closure notice - MCEM.
- ✓ Denial notice - MDEM.

✘ A spenddown is allowed if the applicant qualifies for a category of Medicaid that allows spenddown. If an applicant qualifies for Emergency Medicaid, but must pay a spenddown, check with Medicaid Operations before collecting the spenddown to see if Medicaid will pay for the services. Use the fax sheet designed for that purpose.

http://health.utah.gov/eol/training/workbook/pdffiles/emergency.pdf

http://health.utah.gov/eol/training/slide_shows/ppsfiles/emergency.pps

Foster Care Maintenance Payment

Medicaid Policy 354

Foster Care Medicaid provides medical coverage to children who have been removed from their home, are in the custody of the State and are in an out of home placement to which a Foster Care maintenance payment is being paid.

When a child is placed back in the home with a parent or other specified relative, BES or DWS will determine eligibility for another Medicaid program even if the child is in State custody.

Citizenship & Qualified Aliens

Medicaid Policy 205

- **What is a U.S. citizen?**
  - ✓ **Birth in the U. S.** U.S. citizenship is automatic for individuals born in any of the 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, American Samoa, and Swain's Island. Citizenship is verified by proof of the place of birth.
  - ✓ **Naturalization.** Citizenship may be granted to an individual who was not born in the U.S. or one of its territories if that individual satisfies the legal requirements for naturalization. A naturalization certificate verifies naturalization.
  - ✓ **Born outside of the U.S. to a U.S. Citizen Parent.** If a child is born outside of the U.S. to a person who is a U.S. citizen at the time the child is born, the child is also considered a U.S. citizen for Medicaid purposes.
  - ✓ **Automatic citizenship.** Children both biological and adopted, born in a foreign country automatically become U.S. citizens when they meet **ALL** of the following criteria at the same time on or after February 27, 2001.
    - 1. At least one parent is a U.S. citizen either by birth or naturalization. The parent may become naturalized after the birth or adoption of a foreign born child; **AND**
    - 2. The child is under age 18. If an individual has turned 18 before February 27, 2001, or if the child turns 18 before a parent becomes a U.S. citizen, automatic citizenship does not apply; **AND**
    - 3. The child is living in the U.S. pursuant to a lawful admission for permanent residence and resides in the legal and physical custody of a U.S. citizen parent. Permanent resident status could have been granted before, on or after February 27, 2001. The child must be residing with the U.S. citizen parent on or after February 27, 2001; **AND**
    - 4. For an adopted child born outside the U.S., the adoption has been finalized either in the country from which the child is being adopted or in the U.S. The adoption can take place in another country or in the U.S., and finalization may occur before, on or after February 27, 2001.

    Summary: To receive automatic citizenship, the child simply has to have been adopted by or be the biological child of the U.S. citizen parent, the child must have permanent resident status in the U.S., and be residing with a U.S. citizen parent and still be under age 18, on or after February 27, 2001.

- **Who is a qualified alien?**
  http://health.utah.gov/eol/training/slide_shows/ppsfiles/alien.pps
  http://health.utah.gov/eol/training/workbook/pdffiles/alien.pdf
  - ✓ A qualified alien is an alien who is lawfully admitted for permanent residence under various sections of the Immigration and Nationality Act. Some qualified aliens are barred from receiving full service Medicaid and may receive coverage only for emergency services for five years from the date they obtained qualified alien status. After determining that an alien is a qualified alien, it is necessary to determine if the alien is subject to the five-year bar.
    - See Medicaid Policy Section 205-2 for a complete list and description of persons meeting qualified alien status.
    - Only immigrants who entered the country on or after August 22, 1996, can be subject to the five-year bar. See Medicaid Policy Section 205-2 for complete details.
  - ✓ **Verification of alien status**. Workers must use the SAVE Program to verify the alien status of all people who are not U.S. citizens, except for American Indians born in Canada.
    - SAVE is an electronic automated status verification system used to obtain INS status and to confirm the validity of alien status information that the alien provides.
    - Follow SAVE System instructions to complete the INS verification of immigration status. Complete SAVE System instructions are contained in the Verification Section of the Eligibility Training Manual.
    - A copy of the SAVE verification information should be printed and filed in the eligibility record.
    - Alien registration cards have expiration dates must be renewed. An expired registration card does not change the person's status and does not affect the Medicaid eligibility.
    - The date of entry may be other than the date on the INS documentation and other than the date of "legal residency".
    - If a foster child has been in the U.S **continuously** since prior to August 22, 1996, they are not subject to the five year ban and they can be eligible for Medicaid immediately upon obtaining Qualified Alien Status. You must be able to prove that the child has been in the U.S. continuously since that time. An absence of more than 30 days or multiple absences totaling more than 90 day interrupt the continuous residency. You can use school records, statements from relatives or other people who know the child, or any other record or combination of records that establishes the continuous residency since prior to August 22, 1996.

Citizenship and Identity Requirements

New Medicaid Policy

Effective July 1, 2006

Proof of Eligibility (Section 205-2)

- Under the Deficit Reduction Act of 2005 (DRA) as of July 1, 2006, individuals now most present **documentary evidence** to establish both identity and citizenship. The State Medicaid agency is now required to obtain this information for all current Medicaid recipients and applicants. **All documents must be either originals or copies certified by the issuing agency. Copies or notarized copies obtained from the applicant are not acceptable.**
  - New applicants beginning July 1, 2006, must meet this requirement.
    - The requirement must be satisfied for new applicants before Medicaid eligibility can be established.
  - Current Medicaid recipient must meet the requirement at their first review after July 1, 2006.
    - Current Medicaid recipients must be given a reasonable opportunity to provide the information to satisfy the requirement. Medicaid eligibility may be continued as long as a good faith effort is being made to obtain it. There are no specific time frames. Workers will need to set alerts and document the efforts to demonstrate that the effort to obtain the documents is being made.

New Law in Town…….

Practice and Procedures

What do we do now?

- July 1, 2006, is the start date. If the application was received prior to July 1, 2006, but not being approved until that date or later the new requirements must be met before Medicaid eligibility can be approved.
- To establish U.S. citizenship the document must show a U.S. place of birth or that the person is a U.S. citizen. To establish identity a document must show evidence that provides identifying information that relates to the person named on the document. The only documents that meet both requirements are in Chart 1 on Table IV. For most foster and subsidized adoptive children you will need two documents from Table IV. A document from Charts 2-4 will be needed to verify citizenship and a document from Chart 5 to verify identity. Table IV is located on the DOH website http://utahcares.utah.gov/infosourcemedicaid/
- The original document or a certified copy of the original document used to verify citizenship and identity must be in the case record. Copies or notarized copies are not acceptable.
- The worker must be satisfied that they are viewing an authentic **ORIGINAL** document. Make the best photocopy of the document possible. Front and back if applicable. In clear and legible writing, complete the label and attach it to the photocopied document. Do not cover identifying information on the document. If it is necessary attach the label to the back of the photocopied document. Return the original documents to the client. If the caseworker brings you a copy of the document and verifies that they have seen the original document, you may certify the copy as a copy of the original if you are confident that they could produce a copy of the original if requested.
- The new requirement applies to **ALL** Foster and Subsidized Adoption Medicaid cases. It also applies to ongoing Medicaid for youth exiting foster care at or after age 18.
- ***ALL new*** Medicaid applicants must meet this requirement beginning on July 1, 2006. Current Medicaid recipients must meet the requirement at the first review after July 1, 2006.

- If the worker cannot find the documentation in the case file or imaged then the worker must request the information again regardless of the verification code on PACMIS. Printouts of PACMIS screens may no longer be used for citizenship or identity verification. **HOWEVER,** if another agency has authenticated a document you may use that agency's certified copy. This means you may request and use copies of BES/DWS documents that have been certified as original.
- Vital Statistic Look Up is an acceptable form of citizenship verification. The record can be printed and filed in the case record. The record is an electronic match and does not need to be certified as a copy of the original document. If you have a copy of a birth certificate in the file and you can match the information on the certificate with the information in Vital Records you may certify the birth certificate as a copy of the original. Vital Records information will soon be available in eFind. DWS form 125 may also be used as a verification of citizenship.
- You may certify a birth certificate as a copy of the original if you call the parent or caseworker and they verify that they have a copy of the original document in their possession and that they could produce that document if requested. Only authenticate the documents of those that confirm they can produce the document.
- Souvenir birth certificates that have been issued by a hospital may not be used as citizenship or identification verification.
- For new Subsidized Adoption cases it is reasonable to use the pre-adoptive information while waiting for the new birth and identity documents. There are no specific time limits, but a good faith effort must be made to obtain the new citizenship and identity information. Set alerts and document the efforts made to get the citizenship and identity verifications on the CAAL screen.
- A field will be created in PACMIS to enter the citizenship/identity document information, possibly on the ETRC screen. Workers will need to keep track of all cases that meet the July 1, 2006 criteria so that when PACMIS enhancements are in place, they can go back to the cases they have worked as an application or review and put the proper indication on each individual into PACMIS.
- The person acting as the authorized representative for the client can sign the 61-IC, "Affidavit of Identity".
- Expired documents such as a driver license or student ID can be used to verify identity.
- The Affidavit of Identity is on the BES website http://health.utah.gov/eol/ Form number 61-IC. It has also been attached to the new applications.

- http://www.cdc.gov/nchs/ This is a national web site that can be used to provide clients with information of who to contact to order birth certificates.
- Workers may treat a baby born to a Medicaid recipient as a Medicaid recipient, this means benefits can be continued while the client is given the opportunity to meet the new requirements.
- If denial action is taken because a client was unable to meet the current standard of verification for citizenship and/or identification use the **"CT"** closure reason in PACMIS.

What is Acceptable Verification?

Medicaid Policy 731-3 and 4

- **Some types of verification are preferred over others; however, in the absence of a preferred type of verification, workers may use other methods to verify items of eligibility.**

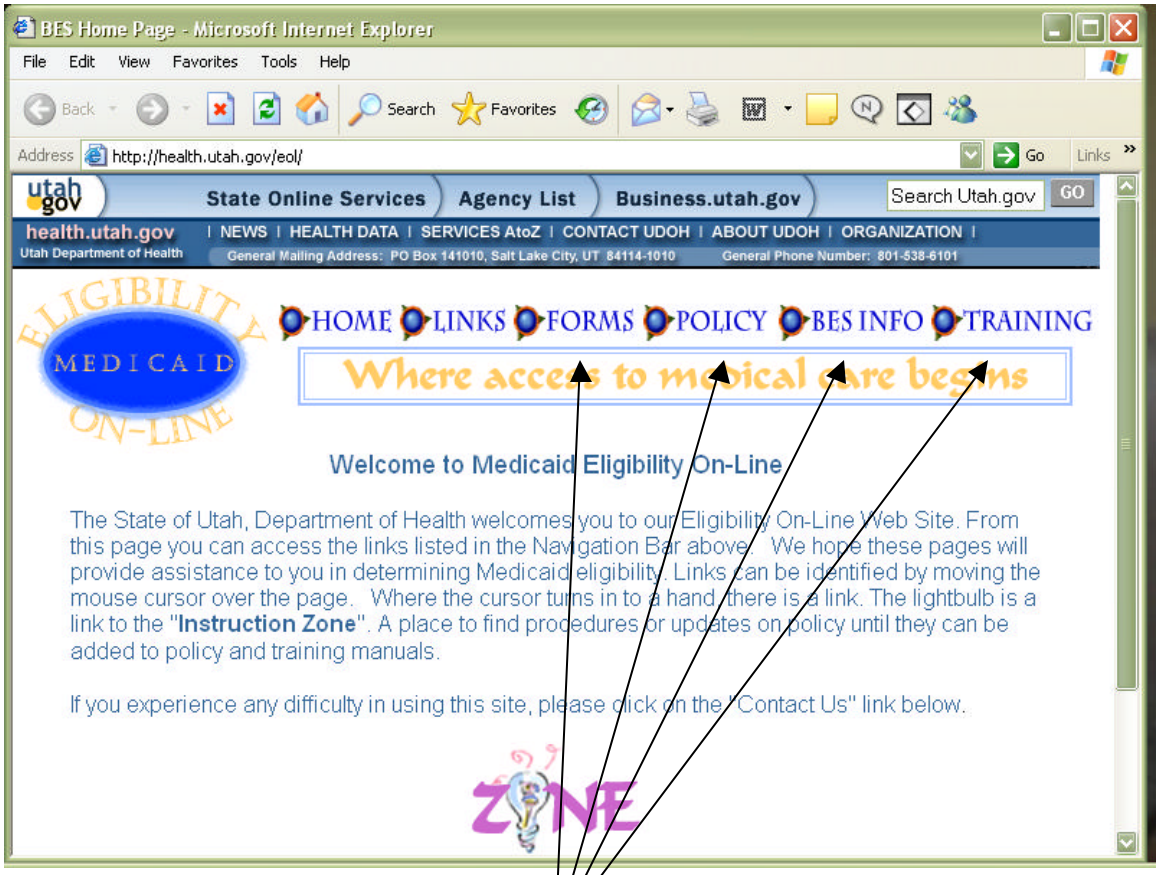
  - **Client's statement (prudent person concept).** This is when an eligibility worker decides to accept the client's statement as verification. Client statement or self-declaration can be accepted for all eligibility factors **except citizenship, identification, alien status and income.**
  - **Hard copy verification.** Verifications may be those items listed on the Verification Tables or other documents accepted by the worker. You do not need to re-verify eligibility factors that don't change such as citizenship and date of birth. For items subject to change, such as income and assets, re-verify them at regular intervals.
  - **Computer interface matches.**
  - **Collateral contacts.** A collateral contact is when an eligibility worker contacts a third party to verify an item for eligibility.
  - **When an SSI recipient is the Medicaid client.** Use the SOLQ interface or SDX interface to verify the receipt and the amount of SSI benefits. The BDX interface can verity the amount of other SS benefits.

Subsidized Adoption Medicaid

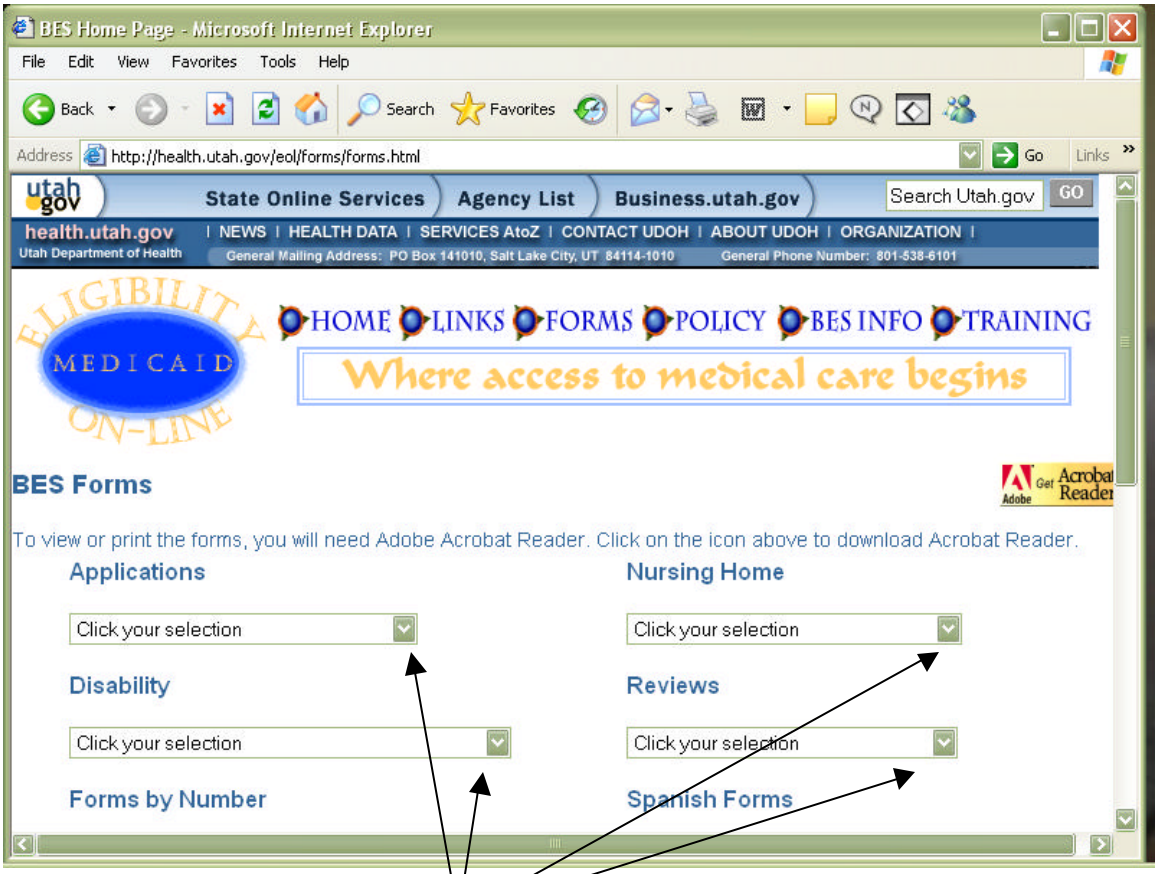
- A child is eligible to receive Subsidized Adoption Medicaid when a current adoption assistance agreement is in effect with a state or local government.
- There is no income test.
- There is no asset test.
- DHS determines the Medicaid eligibility.
- Subsidized Adoption Medicaid is the program of choice over Family Medicaid programs.
- The adoption agreement usually ends the month that the child turns 18. However, the adoption assistance agreement may be extended if the child is determined to be eligible by the state or local government agency that originated the adoption assistance agreement. Subsidized Adoption Medicaid may continue beyond age 18 if the following two requirements are met.
  - **The child has been determined IV-E eligible for adoption assistance.**
  - **A current adoption assistance agreement remains in effect.**
- An adopted child eligible for State funded adoption assistance **is not** eligible for Subsidized Adoption Medicaid after age 18, even if an adoption agreement is in place.
- Children eligible for adoption assistance from another State can be eligible for Utah SA Medicaid through the ICAMA process. Utah's ICAMA specialist will send the required ICAMA paperwork and approval to the regions eligibility staff.

Medicaid Eligibility On-Line

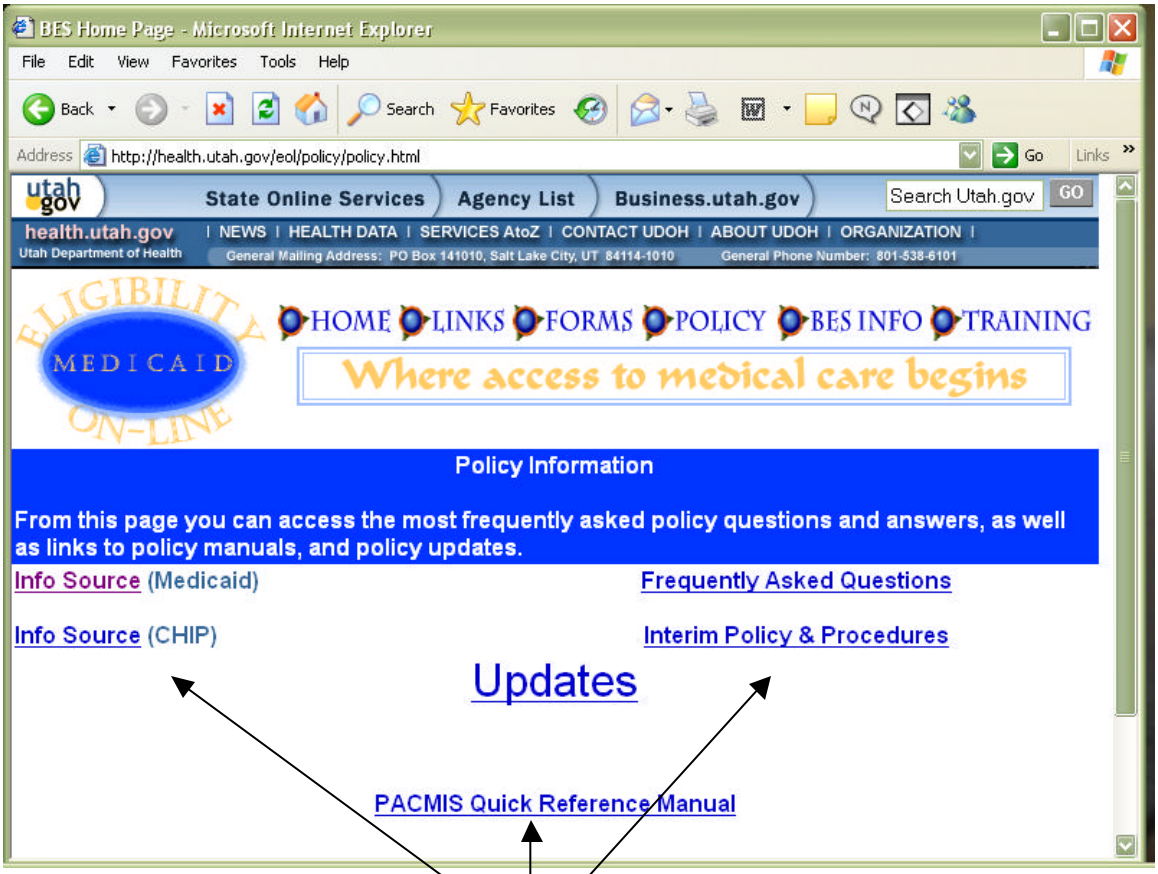
http://health.utah.gov/eol/



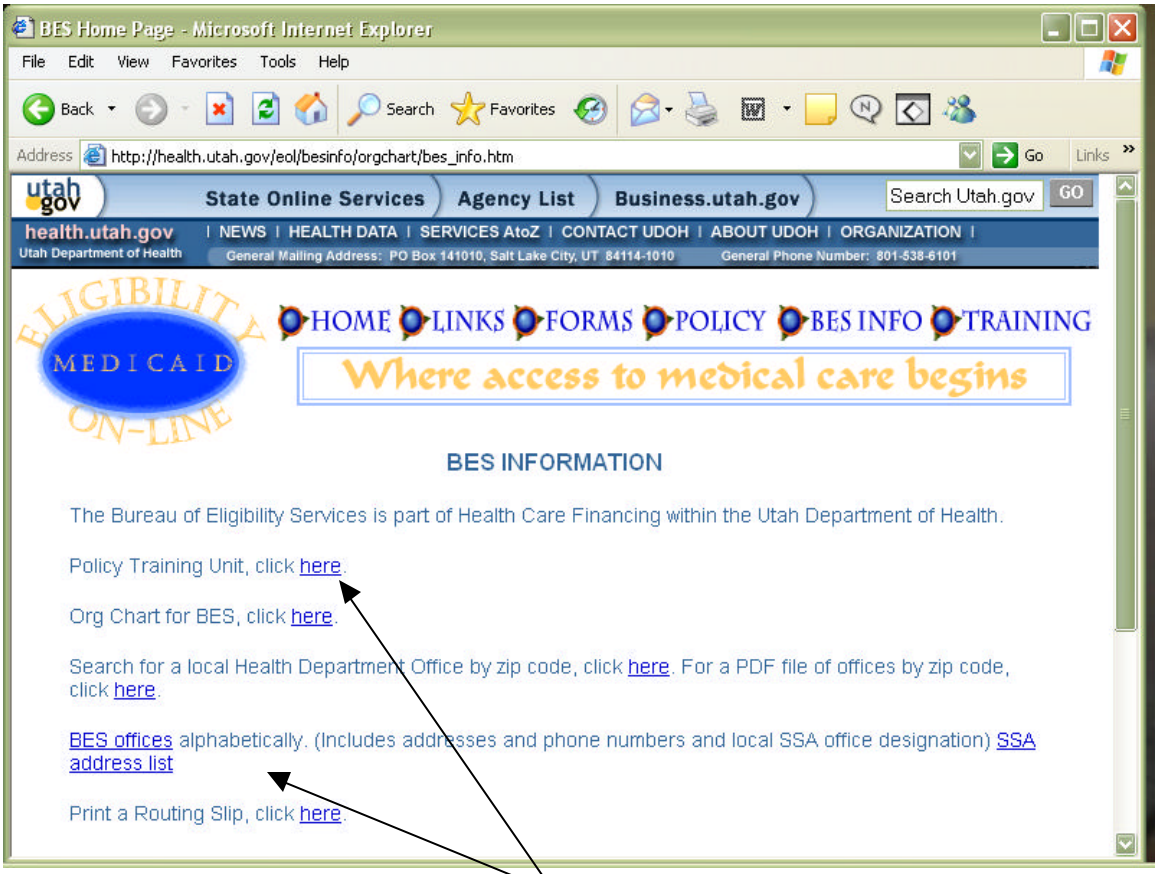
Use the above links to access information about Medicaid eligibility.



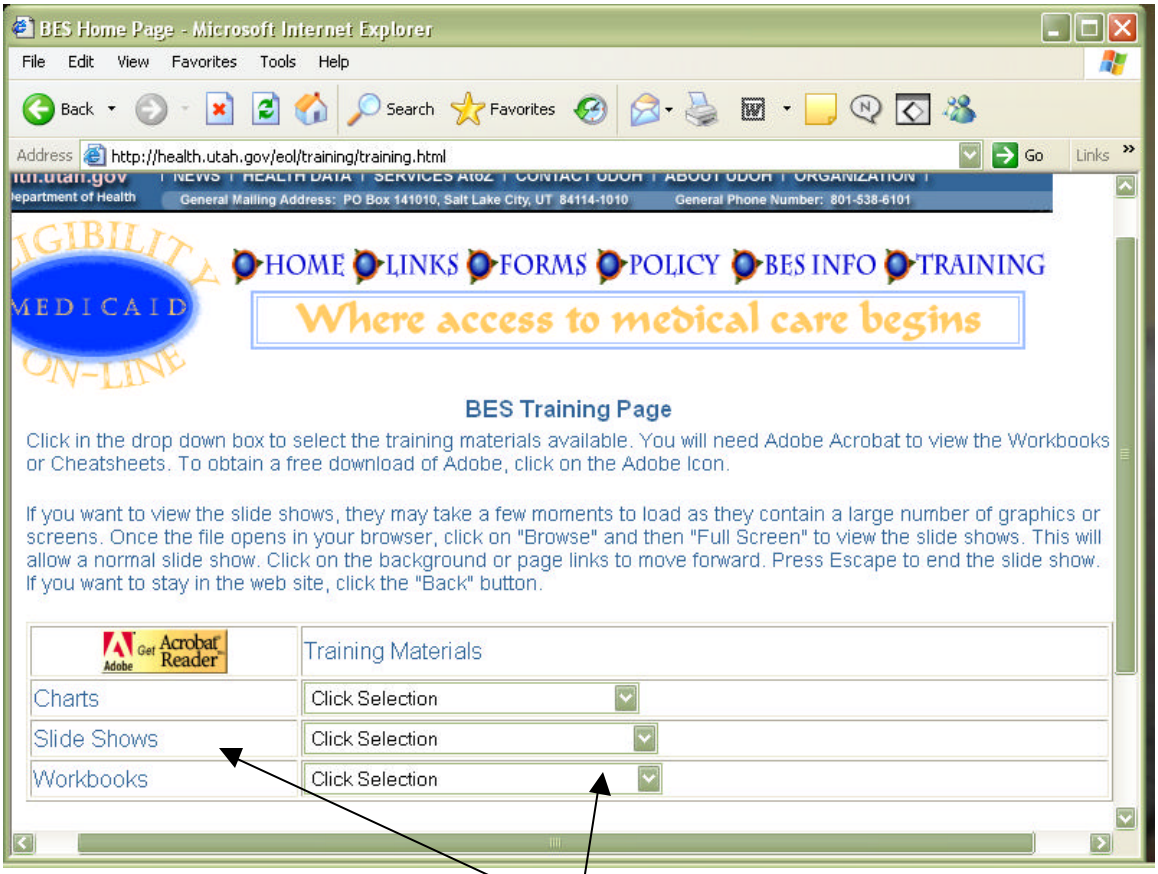
To find a form, make your selection from the drop down box. The adobe acrobat form will load after selection.



Links to policy and procedures.



Links to BES offices and staff.



Links to training materials. Make your selection from the drop down box.

Overpayment Calculation – Identifying an Appropriate Referral

Revised: 04/22/05

Effective: 04/01/05

INTRODUCTION: An overpayment calculation referral must contain the necessary evidence required to calculate and process the overpayment. If the information is not sufficient to refer an overpayment for calculation, please submit an investigation referral. See the procedure titled, Investigation Referral - Submitting. A quality overpayment calculation referral must contain the following information.

1. **Identify the discrepancy in the customer's case.**
2. **Identify the programs involved and apply policy requirements to the alleged overpayment.**
   - The evidence must specify which programs are affected and how.

   ***Example**: Does the evidence prove that the unreported male should have been included in only the financial case or should he also have been included in the food stamp case?*
   - Was the discrepancy a reportable change? (see form 476)
   - Was the discrepancy reported timely?
   - Did you allow advance notice? (if applicable based on the program(s) involved and circumstances of the overpayment)
3. **Determine if the necessary evidence required to calculate and process the overpayment exists in the customer's case file.**
   - The evidence must be hard copy (imaged) document(s).
   - The evidence must cover the entire period (start date through end date) of the alleged overpayment.
   - The evidence must describe the specific actions taken by either the Department or the customer causing the alleged overpayment.
4. **Submit an investigation referral if you do not have the necessary evidence in the case file and it is not necessary information to determine ongoing eligibility.**
   - The Investigator will make the overpayment calculation referral if they are able to gather the necessary evidence.
   - If it is determined that the eligibility specialist made an inappropriate referral it will be cancelled and returned.
5. **Submit the overpayment calculation referral into the Recipient Claims database.**
   - See the procedure for Overpayment Calculation Referral – Submitting.
6. **Narrate all actions on CAAL and/or UWORKS.**
   - Narrative headline must be * Overpayment Referral *
   - In UWORKS notes, select Supportive Services as the Category.
   - Narrative must include the following:
     - Discovery Date.
     - Why the overpayment referral was made.
     - Payment Specialist assigned.
     - Overpayment Calculation Tracking Number.
7. **Set $$ person and program PRAP Alert.**

Overpayment Calculation Referral - Submitting

INTRODUCTION: Referrals must be made into the Recipient Claims Database. Referrals sent through any other method will not be accepted. The Recipient Claims database is located in the intranet.

1. **Access the Recipient Claims Database on the DWS Intranet website.**
   - https://dws.utah.gov/jsp/recipientclaims/index.jsp
2. **See the Recipient Claims Database Training for steps to locate and access the database on the DWS Intranet website.**
   - https://dws.utah.gov/training/103247course/htmContent/dwsdefault.asp

   Note: Follow step 3 if you are accessing the Recipient Claims Database for the first time. Skip to step 4 if you have already saved your worker information into the system.
3. **Enter referring worker information.**
   - Check the data in the pre-populated fields to ensure that your information is correct. If it is not correct, contact the Recipient Claims Program Specialist to update your information in the Database.
   - Enter your user ID in the Worker User ID field. This is the five-character ID used to access switch and PACMIS. It is either ws???, hl???, or or???.
   - Enter your office from the Office drop down menu field. For example, if you are from the Price office, you would select WEP. If you are from the Taylorsville Health Office, you would select HCV.
   - Press the submit button to save your worker information.
4. **Click on the blue Submit button in the Investigation Referral Box to enter the Investigation Referral Page.**

   Note: The Recipient Claims Database will automatically enter the referring worker information. Mandatory information is required to be entered into steps 5-14 for the referral to be successfully submitted into the system.
5. **Enter the customer's name exactly as it appears on CAP1.**
6. **Enter the customer's PACMIS case number.**
7. **Select the customer's zip code in the drop down menu based upon the residential field of CAP1.**
8. **The Discovery Date will auto-populate with the date the referral is made.**
9. **Select the overpayment reason from the drop down menu.**
   - Assets
   - Child Care
   - Earned Income
   - Household Composition
   - Marriage
   - Multiple Cases
   - Other
   - Shelter
   - Unearned Income
10. **Enter the customer's HLCI.**

- The field requires a ten-digit entry.
- PACMIS users must add an additional zero to the start of the number.

11. Enter the referral source from the drop down menu.

- Health referrals are submitted by a Health Department caseworker.
- Investigator referrals are submitted by a DWS investigator.
- ORS referrals are submitted by an Office of Recovery Services caseworker.
- Payment Specialist referrals are submitted by a DWS payment specialist.
- QC Analyst referrals are submitted by a DWS quality control analyst.
- Taxpayer referrals are submitted by a concerned public citizen through the fraud hotline referral systems.
- Eligibility Specialist referrals are submitted by DWS Eligibility Specialists.
- Employment Counselor referrals are submitted by DWS Employment Counselors.
- PAO referrals are submitted by the Public Assistance Overpayment Unit.
- Other State Agency referrals are submitted by State Agencies other than DWS, DOH, and ORS.

12. Enter the detailed reason for the overpayment referral.

- See the procedure titled Overpayment Calculation - Identifying an Appropriate Referral.
- You must include evidence regarding specific names, dates, and places.
- You must include information that describes each program involved and specific time frames in question.
- Note any documents or supporting evidence that are in the DWS file (imaged or hard copy) that will aid in the calculation. Note the date the item was imaged, if applicable.

13. Press the Save Record button to save the referral information into the database.

14. Press the Submit button to send the referral to the payment specialist.

Note: The referral will not be sent to the payment specialist if one or more of the mandatory fields have not been filled. The system will prompt you to fill in the missing information. Upon entering the missing information, you must press the submit button. A confirmation page will appear and provide the PACMIS case number, the overpayment calculation tracking number, the payment specialist assigned, and the payment specialist's contact information. If the confirmation page does not appear, contact the Payment Specialist Supervisor to determine if the referral was made or needs to be reentered.

15. Set $$ program and person PRAP alert.

16. Narrate action taken in PACMIS.

- Narration must include the overpayment tracking number, the payment specialist assigned, and the discovery date.